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Priorities for Investments in Children and Families in Caddo and Bossier Parishes

Application of a Unique Framework for Identifying Priorities

M. Rebecca Kilburn, Shannon I. Maloney

Preface

In Louisiana, the Community Foundation of Shreveport-Bossier pools funds from sources in Caddo and Bossier Parishes, manages the funds, and allocates the funding within the region. (The City of Shreveport is in Caddo Parish; the City of Bossier City is in Bossier Parish.) The foundation recently identified three priority areas for foundation funding: education, health, and poverty. Before launching a campaign to encourage additional community investment in these three funds and prior to issuing grants from them, the foundation engaged in a strategic review of options for making the best use of these funds. The foundation emphasizes the use of data from local and national sources that can steer its gifts toward investments that have the greatest likelihood of making meaningful improvements in the lives of the citizens of the region. The foundation asked the RAND Corporation to assist the community in identifying priority strategies within the three focus areas. This document reflects the findings of the joint work of the foundation, RAND, and the community to narrow the set of activities to which the funds would initially be directed.

While the primary target audience for this report is the Community Foundation and individuals in the Shreveport–Bossier City area, this report is also likely to be useful to others who need to prioritize public or private investments in a broad range of areas. The "Needs-Assets-Best Practices" framework developed to assist with the Shreveport-Bossier investment decisions can be applied in many other settings as well; this document can be viewed as a case study of the application of that framework.

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Summary

After an initial inventory of community indicators in its 2008 Shreveport–Bossier City *Community Counts* annual report, the Community Foundation of Shreveport-Bossier decided to focus existing funding related to children and families on the areas of education, health, and poverty, as well as develop new funds in these areas. These focal areas were very broad, and the foundation realized that further prioritization was required to inform the distribution of the funds in a way that would provide the most benefit to the community. In early 2009, the foundation asked the RAND Corporation to assist with further refinement of priorities for investments, with an emphasis on children and families. In addition to informing the development of funds for the Community Foundation, the findings of this report are likely to be of interest to the broader Shreveport–Bossier City community. Furthermore, the approach used to refine priority areas of investment for this community may be of interest to other communities seeking to prioritize their own investments in children and families.

Approach

We began early in 2009 by convening a series of community meetings, which allowed us to obtain input from community members on the values that should guide a framework for prioritizing investments in children and families. While the Community Foundation would ultimately oversee the disbursement of funds, the foundation wanted the priorities to reflect community values. A broad set of stakeholders in the community joined the meetings: nonprofit organizations that serve children and families, local businesses, grantmakers, faith-based organizations, school districts, volunteer organizations, postsecondary institutions, Latino and African-American organizations, women's organizations, health care providers, early education institutions, justice and law enforcement organizations, government agencies, representatives from the foundation, and others. A few preferences emerged in terms of the relative value placed on different factors that should contribute to selecting priority investments in this community. Community members placed greater emphasis on data and evidence rather than public opinion as a desirable construct for identifying community needs. Furthermore, discussion participants indicated that addressing areas of greatest need was a priority. Individuals also expressed a preference for directing resources toward activities that had been established as "best practices" through evidence-based research.

In parallel with this series of dialogues with community stakeholders, we also conducted a literature review encompassing different strategies for prioritizing investments. We review three major approaches that have been used in similar contexts: assessing needs, inventorying assets, and documenting best practices. Needs assessment generally involves focusing on the outcomes for which the geographic area does the "worst"—or exhibits the greatest "needs"—relative to some comparison group, such as other, similar communities. The asset inventory approach would emphasize building on community strengths that are available for improving child and family outcomes, and these strengths may include an available workforce, infrastructure, volunteer sector, or other community resources. A third popular approach to prioritizing investments has been to employing strategies for which a solid evidence base has demonstrated the potential for effectiveness, so that scarce resources are committed to strategies that have the greatest probability of having an impact.

Framework

Based on the values that community members expressed in the meetings and the results of our literature review, we developed a unique framework to guide the process of identifying priority investments for the community. Rather than selecting the "best" approach from the three major approaches identified in the literature review, we proposed that these approaches be combined into a framework that could be used to narrow the priorities. All three approaches— needs assessment, asset inventory, and best practices—have strengths and include components that the community values. The framework we used to identify priorities for investment in children and families finds strategies that are at the intersection of community needs, community assets, and evidence-based best practices (see Figure S.1). While each of these three standards has been extensively used in the past as a way to guide community investments, this is one of the first instances of which we are aware in which all three are used simultaneously as the organizing principle for prioritizing investments from a broad range of potential areas.

With this framework as a guide, we systematically reviewed data and information related to each of the three approaches in order to objectively identify strategies at their intersection. We reviewed existing secondary data on child and family well-being in the two parishes to pinpoint the outcomes for which the community exhibited the greatest needs. Then we reviewed data on the assets that the community could mobilize to address these needs. Last, we consulted evidence-based research from across the country to locate effective

strategies for addressing the areas of greatest need with the resources available in the community.

Figure S.1
Framework for Investment: Intersection of Need, Assets, and Best Practices

Prioritize strategies in this area

Needs in Shreveport-Bossier area

Assets to deploy for investment

Best practices
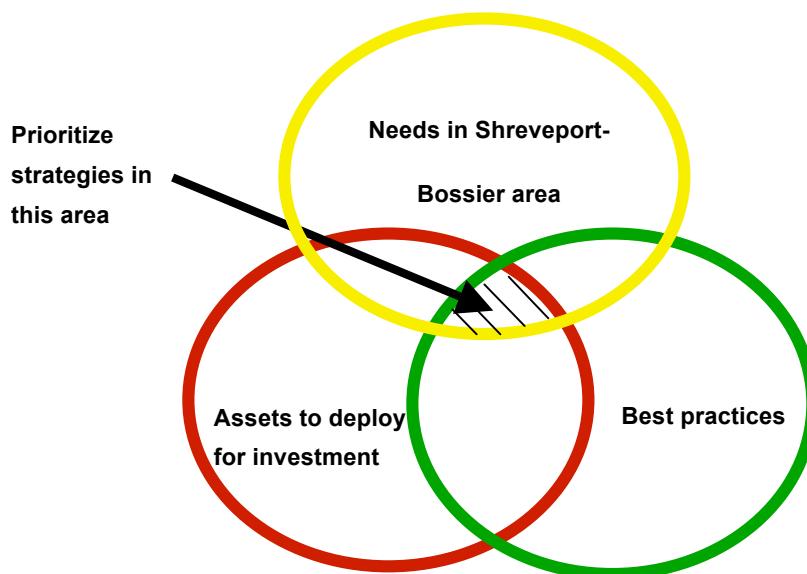
Findings

The analysis identified three priority **areas of need** for children and families in the Shreveport–Bossier City area:

- infant health

- educational attainment

- child maltreatment.

The **strongest assets** in the area that may represent opportunities for improving the well-being of children and families include these resources:

- large quantity of health care facilities and health care providers

- public school teachers and schools

- Barksdale Air Force Base.

Finally, **evidence-based research** indicates that there are a number of effective approaches to improving the areas of need. Table S.1 below indicates the type of approaches that could address the areas of need while taking advantage of the area resources.

We recommend that the Community Foundation consider some next steps to promote their goals of putting their funds to best use. These include creating workgroups to develop plans for implementing investments in the areas identified by this research, identifying specific programs and policies that could be used to implement the priority strategies, and communicating that information to relevant community stakeholders.

Table S.1

Evidence-Based Strategies at the Intersection of Region's Needs and Assets

	Area of Need		
Assets	**Infant Health**	**Educational Attainment**	**Child Maltreatment**
Health care facilities and providers	- Improving women's preconception and interconception health - Pregnancy screening and healthy pregnancy behaviors - Parent education and home visitation programs		- Parent education and home visitation programs
Public schools and teachers	- Educating young women on preconception and interconception health	- Mentoring, counseling - Smaller group settings and personalized instruction - Interventions	- Skill-based curricula or life skills training for children and youth

		emphasizing behavioral change - Academic-focused intensive programs - Data systems to monitor trends and identify at-risk students	
Barksdale Air Force Base	- Same approaches as in health care sector - Train spouses to provide education and home visiting services	- Provide mentors for preteens and teens	- Base awareness campaigns - Parent education and home visitation programs

Acknowledgments

Abbreviations

ACT	American College Testing
CDC	Centers for Disease Control and Prevention
EITC	Earned Income Tax Credit
GTO	Getting To Outcomes
IES	Institute of Education Sciences
LBW	low birth weight
LEAP	Louisiana Educational Assessment Program
NAEP	National Assessment of Education Progress
NCCAN	National Center on Child Abuse and Neglect
NDAS	National Data Analysis System
PPN	Promising Practices Network on Children, Families, and Communities
SAMHSA	Substance Abuse and Mental Health Services Administration
VA	Department of Veterans Affairs

1. Introduction

In Louisiana, the Community Foundation of Shreveport-Bossier pools funds from sources in the Caddo and Bossier parishes, manages the funds, and distributes gifts in the region. (The City of Shreveport is in Caddo Parish; the City of Bossier City is in Bossier Parish.) Since 1961, the foundation has distributed over $35 million in the region. In 2008, the foundation sponsored the first annual Shreveport–Bossier City *Community Counts* annual report, which presented 13 social indicators that reflected economic development and the well-being of citizens in the region (Community Foundation of Shreveport-Bossier, 2008). Based on the findings of this report, the Board of Directors and the staff of the foundation identified three areas of focus for foundation gifts: education, health, and poverty. These three areas were selected out of the larger set of indicators because they exhibited the greatest challenges to the region. In addition to focusing existing grantmaking related to children and families on these areas, the foundation also planned to create new investment funds for each of these areas.

Before launching a campaign to encourage additional community investment in these three funds and prior to issuing grants from them, the foundation leadership decided to engage in a strategic review of options for making the best use of these funds. The foundation emphasizes the use of data from local and national sources that can steer its gifts towards investments that have the greatest likelihood of making meaningful improvements in the lives of the citizens of the region. The foundation asked the RAND Corporation to assist the community in identifying priority strategies within the three funds. This document reflects the findings of the joint work of the foundation, RAND, and the community to narrow the set of activities to which the funds would initially be directed.

How Does a Community Set Priorities?

There are many alternative approaches that a community can use to select priorities (see discussion in Kilburn and Karoly, 2008). These alternatives encompass different values in terms of how to weight different types of data, outcomes, time horizons, and other factors that play into community investments in children and families. For example, some communities may value public opinion more heavily, while other communities may prefer to rely on demographic data. Some communities may insist on a short time horizon, while others may take a longer-term planning approach.

We began the project by hosting a series of community meetings in the first half of 2009 to obtain input and gauge the collective values of the key stakeholders. These stakeholders included individuals from these sectors of the community: nonprofit organizations that serve children and families, local businesses, grantmakers, faith-based organizations, school districts, volunteer organizations, postsecondary institutions, Latino and African-American organizations, women's organizations, health care providers, early education institutions, justice and law enforcement organizations, local government agencies, representatives from the foundation, and others. We aspired to include in these discussions a diverse spectrum of potential viewpoints, individuals from both the private and public sector, representatives from all types of systems that serve children and families (health care, criminal justice, education, etc.), and individuals from underserved communities. We consulted with the foundation, the Louisiana Association of Nonprofit Organizations, individuals from local institutions of higher education, and others to obtain suggestions about who might be willing to participate in the meetings. Meeting invitations were usually distributed to about 100 people via email, and we were generally pleased with the diversity of roles, organizations, and sectors represented at the meetings. We recognize that the link between the project and the community was the Community Foundation. The implication of this is that the individuals who participated in the discussions may not have been a random group of individuals, organizations, or viewpoints and may have had views that were similar to those of the foundation.

In these discussions, a few preferences emerged in terms of the relative value placed on different factors that contributed to selecting priority investments. One such preference was that the participants placed greater emphasis on data rather than public opinion as the appropriate guide for identifying community needs. A second preference was that addressing areas of greatest need should be a priority. A third preference that individuals emphasized in these community meetings was that resources be directed toward activities that had been established as "best practices" through evidence-based research. This was often articulated as a desire to use all available information to make the most of limited resources, rather then "reinvent the wheel," and to make sure that the investments yielded the best possible improvements for children and families. We provide a brief overview of the meeting dates and agendas in Appendix C.

Several other community dialogues were taking place during 2009, including community meetings to obtain input for a Shreveport Master Plan project, as well as discussions related to schools and school district activities, and other community initiatives. We either ensured that a project representative attended

some of these other discussions or reviewed notes from them in order to capture any additional information that was relevant to our work. Throughout this process, we aimed to balance our conviction that community input was invaluable with community members' concerns that more discussion was taking place than action.

Framework for Prioritizing

As discussed in more detail below, we also conducted a literature review on alternative approaches to prioritizing community investments, with an emphasis on those directed toward children and families. We combined the information from the literature review with the factors that the Shreveport-Bossier community valued to develop a unique framework to guide decisionmaking on this issue. We proposed a hybrid approach that combines several of the traditional ways of choosing priorities and, as a result, takes advantage of the strengths of each approach. At the same time, this framework incorporates information from existing secondary data about the community and also draws on best practices from around the country.

Specifically, we have used a framework that identifies priorities for investment in children and families by finding the strategies that are at the intersection of community needs, community assets that can be deployed for improving child and family well-being, and evidence-based best practices for improving children's outcomes. While each of these three standards has been extensively used in the past as a way to prioritize community investments from a broader set of possibilities, this is one of the first instances of which we are aware in which all three are used simultaneously as the organizing principle for prioritizing areas for investment.

Using this framework as a guide, we systematically reviewed data and information related to each of the three approaches in order to objectively determine what was at the intersection (see Figure 1.1). First, we reviewed existing secondary data on child and family well-being in the two parishes encompassing Shreveport and Bossier to discover the outcomes of greatest need for the community. Second, we reviewed data on the assets that the community could bring to bear to address these needs. Finally, we consulted evidence-based research from across the country to identify effective strategies for intervening to address the areas of greatest need with assets available in the community.

Figure 1.1
Framework for Investment: Intersection of Need, Assets, and Best Practices

Needs in Shreveport-Bossier area

Prioritize strategies in this area

Assets to deploy for investment

Best practices
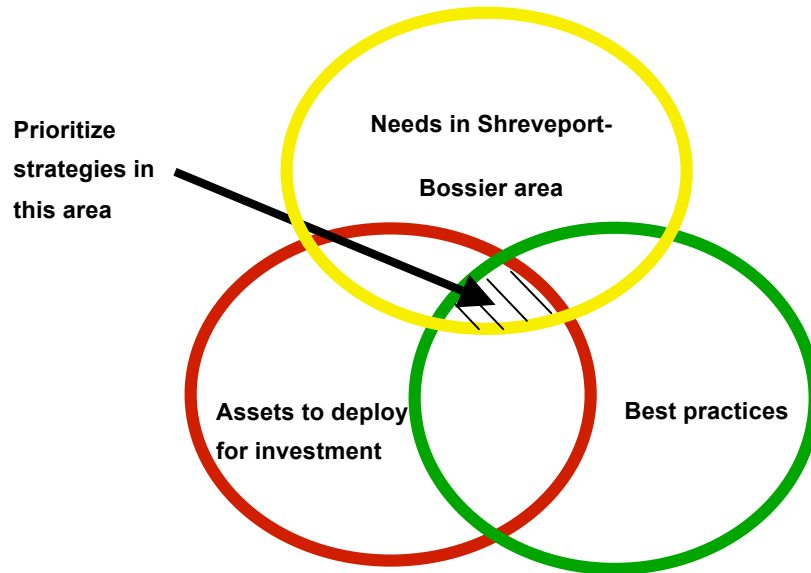
Outline of this Document

Chapter Two provides an overview of the three approaches to prioritizing investments that form the foundation for the framework used by this project. These include needs assessment, identifying assets, and best practices. Chapter Three presents our findings from using data to pinpoint the intersection of needs, assets, and best practices. Chapter Four concludes with recommendations based on the research.

2. Approaches to Identifying Priority Investments

This chapter provides an overview of the three major approaches to identifying priority investments that our framework draws upon. These include needs assessment, identifying assets, and best practices. The chapter ends by contrasting this "Needs-Assets-Best Practices" framework, which helps communities prioritize areas for investment, with some frameworks that provide communities with guidance about how to implement interventions once they have identified their priority investments. These implementation frameworks incorporate aspects of community needs and capacity as well as evidence-based practice guidelines, and communities may find these useful as they embark on next steps.

Needs Assessment

Faced with a vast array of options for spending within a limited budget, community organizations must choose which programs to fund and which to leave behind. How to make this choice in an equitable or efficient way is not always clear. Needs analysis provides a data-oriented platform for making strategic funding decisions.

Needs analysis is the process of identifying and prioritizing deficiencies so that an agency or community organization can allocate its resources for the greatest benefit (Harlow and Turner, 1993). The concept of a "need analysis" originated in the 1960s (Kimmel, 1977) out of legislators' desires to be more selective about which social programs they funded. Rather than fund all proposed initiatives, legislators sought to make public spending more efficient by focusing on programs that offered evidence to support their existence. For a program to receive funding, it had to demonstrate a need for the services offered and show that the program itself was effective (Kimmel, 1977). Together, these requirements aim to provide an objective and logical framework for establishing the need for programs and the likelihood that program spending would have an impact.

Despite intentions to infuse program spending decisions with logic and clarity, needs analyses require decisionmakers to make value judgments about need. What constitutes a need depends on the goals, values, and perspective of the person or entity defining the need (McKillip, 1987). For example, a community

with ample economic resources might value the arts and have as a goal that all children receive adequate exposure to arts and culture. This community may be facing a choice between boosting arts education or building a new museum. Whether this community has a need and which program should be funded depends on the baseline the community has established as adequate arts exposure.

Identifying Needs

Before initiating the needs analysis process, an organization must decide on a baseline or set of criteria to measure need (Cline and Seibert, 1993). The criteria loosely represent an ideal state of the world. They are the goals that the organization wishes to achieve, and need is measured as discrepancies between the current state and the ideal state (Watkins and Kaufman, 1996). Criteria may derive from professional standards or from subjective preferences, such as community or local expert aspirations. Needs analyses often employ more than one set of criteria for identifying needs (Elliot et al., 2000; Nolin et al., 2006; Loos, 1995).

Objective criteria can be thought of as benchmarks or standards that are set by evidence-based research. They often rely on social indicators or other numerical data about a population. Typically, benchmark criteria are measured by thresholds, comparisons, trends over time, or utilization rates.

Thresholds are set standards that represent a minimum acceptable level of the desired outcome (McKillip, 1987). They are static numbers and are usually stated as percentages. Centers for Disease Control (CDC) recommendations for public health standards, such as target immunization rates, Environmental Protection Agency (EPA) guidelines for environmental hazards, and the Federal Reserve target inflation rates are examples of threshold benchmarks. Thresholds also apply at the individual level. Babies born weighing less than 2,500 grams (5.5 lbs) are classified as having a low birth weight (LBW). LBW infants have a much lower chance of survival than their peers who are born at a healthy weight (United Nations Children's Fund and World Health Organization, 2004).

A community may instead use its performance relative to peers as the standard (McKillip, 1987). These types of benchmarks are useful when no clear guidelines or evidence exists to establish a minimum threshold. For example, a community may be interested in reducing teen pregnancy or improving adult literacy. One way to gauge where the community stands is to look at pregnancy and literacy rates in communities with similar characteristics. The community could compare its own rate with the average rate for similar locations, or it could rank its

standing among other locations. If pregnancy rates are far above the average or the community ranks near the bottom for adult literacy rates, the community might classify adult literacy or teen pregnancy as need areas.

Communities may also examine trends, making comparisons within the community over time (Chinman et al., 2004). A community might discover that its current percentage of high school graduates is much lower than it was ten years ago. A quick examination of graduation rates for the past ten years could reveal that graduation rates have been steadily declining over time. The community would likely view this downward trend as an indicator of need and make efforts to improve graduation rates for its students. The community may establish a goal of increasing the percentage of students graduating each year until it achieves the same percentage that existed ten years ago, or try to raise the rate even higher.

Subjective criteria for measuring need include resident perception and provider/expert opinion. With subjective criteria, an emphasis is placed on needs asserted by the community members. Residents make their own analyses based on felt or perceived discrepancies between the current state and the community members' own conception of the ideal state (McKillip, 1987). Experts and providers give their opinion about community needs based on their interactions with residents and their expert knowledge (Williams and Yanoshik, 2001).

Subjective criteria are useful when the organization feels that social indicators do not provide a complete picture or when some aspect of the numerical data requires clarification from the community. Often, community input is solicited when the organization believes that unknown cultural factors have specific bearing on the needs analysis, or that a group of residents may have beliefs or traditions that are not apparent through social indicator data but could impact community trends (Nolin et al., 2006; Loos, 1995; Batsche et al., 1999). For example, in 2006, Washington State published an adolescent needs assessment report in which researchers initially created a snapshot profile of the community using social indicators then supplemented it with explanatory factors gathered through focus groups (Washington State Department of Health, 2006). Additionally, organizations often include community feedback with the hope of establishing buy-in from community members and improving the chances of program success (Billings and Cowley, 1995). However, note that the distinction between subjective criteria for assessing need and criteria based on objective data may not be sharp—individuals necessarily employ subjective interpretations when analyzing data. Additionally, subjective community perceptions are likely to be valuable as communities take action after identifying priorities. Below, we

discuss some frameworks that guide community implementation of social services, and some of these incorporate subjective information in order to inform successful implementation.

Measuring Needs

Objective, standards-based data may be collected through existing databases or by collecting new data through surveys, tabulations, or administrative data (Harlow and Turner, 1993). Standards-based data are usually numerical, with an emphasis on aggregate, population-level statistics. Social indicators, such as eligibility for the Earned Income Tax Credit (EITC) or the rate of LBW, are often used to infer information about societal factors related to the needs of interest. Most standards-based data are collected and reported from individual residents and aggregated to compute statistics about the community as a whole. Utilization benchmarks may also obtain resident use and capacity data from program records.

Subjective or felt needs are collected from residents and experts through surveys, focus groups, and interviews (Billings and Cowley, 1995). Typically, information is obtained from residents through focus groups or surveys to elicit information from a large number of residents. Focus groups provide the unique opportunity for residents to come together and discuss community needs as a collective unit. For organizations interested in establishing community buy-in, focus groups may be a good starting point for building consensus and interest among residents.

Expert or provider opinion is usually collected through interviews or panels. Organizations using this method are probably interested in information available from a select number of individuals with highly specialized knowledge about the community or the need area. Interviews allow needs analysis staff one-on-one access to the expert to elicit a greater level of detail. Experts have the opportunity to explain their perspectives and rationales thoroughly, and interviewers may cover a wider range of material than may have been possible in a group setting.

Assessing Needs

A thorough data collection effort will likely produce several potential areas of need. Organizations are now tasked with deciding which need areas demonstrate deficiencies strong enough to warrant program funding and which do not. The assessment portion of needs analysis applies one or more methods for determining the relative deficiencies across need areas. Common

methodologies include measuring the distance from a benchmark; rating or comparisons; marginal analysis; and consensus. The methodology used for a given assessment will depend on the goals of the organization and the type of data used for needs identification.

Organizations that have used benchmarks as criteria for needs identification will likely employ rating, measuring the distance from a threshold, or marginal analysis as assessment techniques. The ideas behind rating and distance from threshold are straightforward. In the distance-from-threshold method, an organization hoping to achieve some benchmark measures how far the current state of being is from the established benchmark. In the immunization example, if the target threshold is 90 percent, a distance-from-threshold measurement would simply assess how far the current rate is from 90 percent. Similarly, needs identified through comparison criteria can be assessed by the distance from the average or how far the need area is from the desired ranking.

An assessment of needs using ratings attempts to measure the relative importance of needs. Ratings are likely to involve some value judgments about importance. Organizations may achieve some objectivity by identifying and quantifying the potential consequences of failing to address different needs (Watkins and Kaufman, 1996). If rating is based on numeric benchmark data, a more quantitative assessment may require additional analysis or data gathering. For example, an organization may try to forecast trends or quantify social impact in terms of scope or number of people affected.

Marginal analysis uses an economics-based approach to prioritize needs. The central idea is to determine which needs provide the greatest benefit for each unit of effort spent fixing the need (Donaldson and Mooney, 1991). Typically, marginal analysis uses monetary costs and gains to measure efforts and benefits. The question may be thought of as how much "return" would be gained from addressing each need for each dollar spent. This concept is related to that of cost-effectiveness (Karoly et al., 2001).

Some needs, such as economic growth or jobs programs, will produce monetary benefits when addressed. Others, such as adult literacy, may be harder to assign a dollar value to. In these cases, other quantitative measures may be used. For example, an organization deciding between funding a teen pregnancy program or an adult literacy program may look at how many individuals will have their lives improved as a result of one dollar spent on each program. To obtain the individuals-per-dollar figure, simple calculations, such as dividing the total number served by the total cost, may be necessary. Cohen (1994) describes a

qualitative approach to marginal analysis in which experts were asked to judge the effects of minute changes in program spending (Cohen, 1994).

Needs analyses concerned more with community input may use citizen ratings as a guideline for assessing relative need. Rating in this sense differs slightly from the objective case, as residents or providers use internal values to judge importance of different needs and then report their judgment to the organization. Organizations may ask community members to rate the strength or importance of the needs facing the community and use the ratings at face value. Alternatively, frequencies may be used to determine which needs are mentioned most often by community members, with ratings then assigned to needs based on frequency of mention (Nolin et al., 2006). Rating information may be collected through surveys, interviews, or focus groups.

Organizations employing community feedback criteria may also use consensus as a method for assessing which needs to address. Consensus is simply establishing agreement among multiple sects of the community about which needs are more important to that community. This may require holding community meetings with residents and service providers, along with any other interested stakeholders, to discuss the identified need areas and brainstorm priorities. Since most organizations that use community input are interested in building support within the community, consensus is an important factor for these analyses. If multiple stakeholders agree on a set of top priority needs, building coalitions, garnering community cooperation, and ensuring resident participation may be easier tasks to manage.

Our Approach to Needs Assessment

We propose using objective criteria based on social indicators from the KIDS COUNT database (Annie E. Casey Foundation, 2010) and other community needs indices. Our goal is to provide an objective and timely overview of the key needs facing the Bossier and Caddo Parishes. The scope of this analysis includes the well-being of the communities in the areas that were identified in the Community Foundation's first phase of needs assessment: education, poverty, and health.

We compared parish averages with those of Louisiana and the United States, using distance from the average as our benchmark for establishing need. We selected a subset of children's education, health, and poverty indicators that are common to most or all of the community needs indices we reviewed, and we obtained input on the indicators from the Community Foundation and community groups. Our data are the most current statistics available (data

sources for each indicator are listed in Appendix B) for these indicators for Caddo and Bossier Parishes, the state of Louisiana, and for the United States. Collecting currently available statistics, rather than collecting our own data, allows us to easily compare a wide range of social indicators for a more comprehensive analysis.

An important consideration when analyzing data to identify community needs is the quality and completeness of those data. While there are many data sources available that are related to the topics we examine here, we chose to rely on the KIDS COUNT county data because they meet several standards that were important to us. First, this data source provides data at multiple geographic levels—county, state, and national—which enabled us to compare Caddo and Bossier Parishes with state and national data. Second, the KIDS COUNT data include indicators that meet seven criteria that the KIDS COUNT project has established, including that the data are available from reliable sources, are issued annually, are consistent over time, and that the data have a relatively unambiguous interpretation (see Annie E. Casey Foundation, 2009, p. 138). Finally, it is likely that these data will also be available in the future, which will permit the community to track its progress on improving these indicators. While the data series we use gets high marks for data quality, it does suffer from some shortcomings in terms of completeness. For example, KIDS COUNT does not include indicators related to childhood obesity or children's exposure to trauma. However, we were not able to locate county-level data that would provide indicators on other outcomes that met minimal standards of data quality.

As discussed above, there is no "correct" baseline group to which Caddo and Bossier Parishes should be compared. We compared the most recent data available for these parishes with the previous five years of data for these parishes, to state of Louisiana data, and to data from the entire United States. There were very few clear trends in the data comparing the most recent years of parish data with those from earlier years, so we do not present those comparisons here. We chose an approach that compares the most recent parish data with each other, the state of Louisiana, and the United States as a whole. While these are arbitrary comparison groups, we feel that these comparisons provide a relative measure of how the parishes are doing relative to geographic units that have somewhat similar characteristics (the other parish and the state) as well as a measure relative to a broader comparison group (the nation as a whole). Community members expressed an interest in the latter comparison in addition to comparisons to more "similar" geographic units, since the state of Louisiana is known to have relatively poor outcomes relative to the rest of the United States.

Strengths and Weaknesses of This Approach

Needs analysis provides structure to the identification of priorities, and the use of existing secondary data adds some objectivity to the task of identifying areas for improvement. The motivation behind needs analysis is to provide reasonable assurance that organizations are allocating resources toward areas with the greatest need. Several approaches to conducting needs analysis have arisen in the years since its inception, and this variety allows organizations to adapt a needs analysis so that it meets the current goals and community values. Organizations may combine approaches or select one to emphasize a particular goal. In this sense, needs analysis uniquely offers a degree of objectivity and structure, while leaving room for flexibility and stakeholder values.

The unfortunate consequence of this flexibility is that there is not a clear-cut "best" approach to conducting needs analysis. Multimethod approaches may be time-consuming and resource-exhausting. While there is some evidence that different approaches yield similar results (Elliot et al., 2000; Williams and Yanoshik, 2001), other studies find vastly different results between approaches (Murray and Graham, 1995; Nolin et al., 2006; Ross, 2008). It is difficult to know whether the relatively high level of investment needed for a needs analysis provides a sufficient level of assurance to warrant the investment.

Needs analyses are also somewhat narrow in their focus. These analyses place a large emphasis on identifying the weaknesses in a community but largely ignore the larger context. Needs analyses in their traditional form do not take a comprehensive snapshot of the community. They focus on what is not working and ignore what is. This is a lost opportunity for learning. Further, it fosters a negative and disempowering or dissatisfied attitude. Needs analysis is only one part of a larger, comprehensive community profile. In isolation, it is unlikely to produce the strong, positive transformation that communities seek. Some of these shortcomings of needs assessment helped motivate the evolution of an alternative approach to prioritizing investments—asset inventories—which we discuss next.

Identifying Assets

In the early 1990s, an alternative to "needs assessment" as an approach to community development began gaining popularity. Known as "asset mapping," or "asset-based" or "strengths-based" planning, it was often viewed as a superior approach to needs assessment, although it was occasionally seen as a complement rather than an alternative to needs assessment (Beaulieu, 2002).

Asset mapping does not in fact involve a geographic map, but rather is the systematic accounting of all of the resources at the individual, private organizational, and governmental levels that can be committed to community improvement. The asset-based approach is viewed as having several advantages over the needs-assessment approach. First, it focuses on positive aspects of the community rather than stressing the community's shortcomings, thus providing the perception that change is more feasible and less daunting. Second, it stresses existing conditions rather than ideal conditions that may seem unattainable. Third, the assets- or strengths-oriented approaches tend to generally employ bottom-up planning processes rather than top-down planning approaches, with an emphasis on resident participation, individual involvement in solutions, and community voice.

The pioneers of asset mapping, Kretzmann and McKnight (2003), often focus their community capacity inventories on uncovering hidden talents in communities, embodied in individuals. These community inventories may be oriented toward "finding and mobilizing" the assets in a very small community, such as a neighborhood (see Kretzmann and McKnight, 1993, for example). Additionally, the methods used in these types of asset mapping exercises typically include surveys of individuals in which very detailed information on a person's skills, current volunteer activities, association memberships, and other community-related activities are catalogued.

The scope of our analysis is much larger—we seek to characterize the resources that the Shreveport-Bossier metro area can mobilize rather than individual neighborhoods within the two parishes. As a result, our inventory takes a more macro perspective than most asset mapping exercises. We focus less on individuals' resources than on the resources at the organizational, institutional, and governmental level. Furthermore, rather than surveying individuals, we rely on data available from secondary data sources with aggregated information such as workforce statistics, the size and activities of private and public organizations, and government resources deployed for different purposes.

The empirical foundations of asset inventories are less solid than those for needs assessments. This is due in part to the relative paucity of data on community assets relative to staples of public health and education statistics that form the backbone of needs assessment. Furthermore, empirical metrics for pinpointing community strengths are less clear than the approaches to needs assessment, in part because relevant comparison groups are less clear. For all of these reasons, asset inventories—even those that are empirically based on reliable data—often involve a great deal of judgment in addition to statistical analysis.

The presumed audience for this report is people already generally familiar with the Shreveport-Bossier area. Hence, we do not report such background information as the history of the area, the overall demographics, or the topography. We encourage readers to consult the 2008 *Community Counts* publication (Community Foundation of Shreveport and Bossier, 2008) or other references for this type of background information.

Best Practices

There is little question that policymaking and funding has entered a new era in which "evidence-based" programs and practices are preferred and even required in some instances (McCall, 2009; O'Connell et al., 2009). The trend toward evidence-based programming has pervaded child and family services as well as other social sectors (Buysse and Wesley, 2006).

While different organizations use different standards for what constitutes evidence, most evidence standards specify a set of minimum criteria for scientific rigor that the research must meet (National Research Council Committee on Scientific Principles for Education Research, 2002). These include the adequacy of the research design, such as the comparability of comparison groups; the size of the samples; the magnitude of impacts; statistical significance; and low attrition (e.g., Promising Practices Network, 2009c; Coalition for Evidence-Based Policy, 2007; U.S. Department of Education, 2008).

The reason for insisting on evidence-based programming is the theory that it will raise the likelihood that the limited resources available to dedicate to child and family services will actually improve outcomes (Buysse and Wesley, 2006; McCall, 2009). However, in order for the promise of evidence-based information on child and family services to be realized, several conditions must be met. First, it must be the case that an extremely rigorous evaluation has been conducted on the topic of interest. Given the time and expense required to conduct randomized trials and other rigorous evaluations, there are relatively few specific and replicable programs and practices that have been evaluated in ways that meet the highest standards of rigor. For instance, the Coalition for Evidence-Based Policy's "Top Tier Evidence" website identifies social programs meeting the evidence standard set out in recent legislation, such as the Consolidated Appropriations Act of 2008 (P.L. 110-161) and the Omnibus Appropriations Act of 2009 (P.L. 111-8): "'well-designed randomized controlled trials [showing] sizeable, sustained effects on important . . . outcomes'" (Coalition for Evidence-Based Policy, 2010). This exercise has identified only two interventions for

children age 0–6 that meet this standard, and four such interventions for children age 7–18 (Coalition for Evidence-Based Policy, 2010).

Another challenge that limits the application of evidence-based practice is that information about how to replicate evidence-based programs is often lacking. Replication materials or technical assistance may not exist, and the research publications documenting a program's effectiveness may not describe the program in sufficient detail to faithfully replicate it (McCall, 2009). Another challenge is that cost information is rarely provided in research about program effectiveness.

Finally, replicating evidence-based programs or practices requires some underlying capacity on the part of the organization that is going to undertake the replication, and organizations vary widely in their abilities to plan, implement, sustain, and evaluate ongoing programs. While there is evidence that technical assistance and training can improve organizational capacity (Chinman et al., 2005; Chinman et al., 2008), establishing this underlying condition is time-consuming, expensive, and requires a great deal of organizational will and commitment (Summerville, 2009; Blase et al., 2009).

The best practices information that we draw upon for this project recognizes both the theoretical strengths and practical limitations of using evidence-based research to inform practice. Rather than requiring all information to meet a gold standard of research rigor, such as requiring a randomized trial evaluation, we instead point readers to the best available evidence on the relevant topics and help the reader understand the strength of that evidence. The reasoning behind this approach is that the community is unlikely to abandon attempts to solve problems for which there are no randomized trial evaluations but, at the same time, want to weight their investments toward those that have the greatest likelihood of success.

In general, we will refer readers to best practice information presented on the Promising Practices Network (PPN) website (www.promisingpractices.net). This site presents information on a broad range of strategies designed to improve outcomes from the prenatal period through age 18 for which there have been rigorous evaluations. The evidence standards used by PPN include an extremely rigorous "Proven" standard and a less rigorous "Promising" standard (see Promising Practices Network, 2009c, for a detailed description of the evidence criteria). An advantage of using the PPN site as a springboard for evidence-based information is that it points users to many other sources of evidence-based information that meet the PPN standards for the "Promising" or higher evidence designations.

The Intersection of Needs, Assets, and Best Practices

These three approaches to prioritizing investments in children and families all clearly have strengths and weaknesses. Rather than relying on one of these as the guiding principle for narrowing the scope of investments, we suggest that the three approaches be combined and that the priority investments be those at the intersection of needs, assets, and best practices (see Figure 1.1).

In the literature on social service implementation, others have recognized that needs assessment, asset inventories, and best practices can all add value and help organizations achieve their objectives. For example, the "Getting To Outcomes" (GTO) process to improving community implementation of social services includes these three activities as part of its 10-step process and probably comes closest in spirit to what we propose here (Chinman et al., 2004; Chinman et al., 2008). However, GTO assumes that the community has already identified a priority area for intervention—such as teen substance abuse—and, in such cases, GTO will help the community effectively implement that intervention. Similarly, the Communities that Care prevention-planning system (Hawkin and Catalano, 2005) guides users through the process of obtaining community buy-in, identifying community risk and protective factors, and tracking progress toward promoting positive youth outcomes and preventing problem behaviors, including substance abuse, teen pregnancy, violence, and dropping out of school. Like GTO, Communities that Care assumes that a community has identified the priority area for investment—preventing youth problem behaviors—and guides the community through the process of identifying and implementing specific strategies for investing in that priority area. Another related tool is the Strategic Prevention Framework that the Substance Abuse and Mental Health Services Administration (SAMHSA) developed (U.S. Department of Health and Human Services, 2010). The Strategic Prevention Framework provides tools that help communities successfully deliver effective mental health promotion and substance abuse prevention programs. The Strategic Prevention Framework helps communities use epidemiological data to assess their prevention needs, build prevention capacity, develop action plans, implement evidence-based program and practices, and monitor outcomes.

In sum, the Needs-Assets-Best Practices Framework that we propose here is an approach for identifying what will be the priority area for intervention, whereas the tools just described help communities successfully implement interventions after they have identified a priority area for investment. As discussed in Chapter Four, we encourage the Shreveport-Bossier community to use these or similar

tools as they move forward in implementing interventions in their focus areas of health, education, and poverty.

3. Findings

We now present findings from analyses of data that provide information about the needs and assets related to children and families for the Shreveport-Bossier area. We also provide an introduction to evidence-based information on approaches for addressing the priority areas identified in the data analysis. We first present results from the needs assessment, then we provide information about assets related to the high-need outcomes. This chapter concludes with information about relevant best practices. We conducted the data analysis and moderated community discussion on the three components of the Needs-Assets-Best Practices framework in this order. While we found it to be efficient to conduct the analysis in this order, it is not necessarily the case that the process of identifying the intersection has to be done in this order.

Needs Assessment

We identified eight indicators as high-need areas for Bossier Parish, Caddo Parish, or both parishes, and these indicators are in three broad areas:

- *Infant Health:* preterm births, infant mortality

- *Child Maltreatment:* neglect, physical abuse, sexual abuse

- *Academic Performance and Educational Attainment:* math proficiency in 4th grade and 8th grade and high school graduation.

In each case, the indicator for at least one of the parishes was either 30 percent worse than the average for the state of Louisiana or 50 percent worse than the average for the United States. These are arbitrary cutoff levels, but these cutoffs served to narrow the original set of more than 30 indicators to eight indicators. Furthermore, the choice of the state of Louisiana as the baseline for the figures in this chapter is also arbitrary, but it has the advantage of allowing the data for the two parishes to be compared side by side. We now discuss each of these eight indicators in more detail. Findings for the other indicators are in Appendix A, and a list of data sources and definitions are in Appendix B.

Infant Health

Caddo Parish shows high need in two areas related to infant health: infant mortality and preterm births. Caddo Parish's rate of infant mortality is 30 percent

higher than Louisiana's average and 50 percent higher than the U.S. average. Bossier Parish data indicate that this parish fares well in one of the measures of infant health, but is slightly below average in the other. Preterm births are those that occur prior to 37 weeks after conception. A full-term birth is generally considered to be 40 weeks after conception.

Preterm Births. As indicated in Figure 3.1, Caddo's preterm birth rates differ from the state and national averages by more than 30 percent. On average, approximately 17 babies out of 100 were born prematurely each year between 2002 and 2006 in Caddo Parish. Louisiana averaged 13 premature births out of 100, while the United States had approximately 12 per 100 births, across similar time periods. In addition, both Bossier and Caddo Parish have shown steady increases in premature birth rates from 2002 to 2006. Caddo Parish's rate increased by 35 percent, from 14.5 premature babies per 100 births in 2002 to 19.7 premature babies per 100 births in 2006.

Figure 3.1
Preterm Births
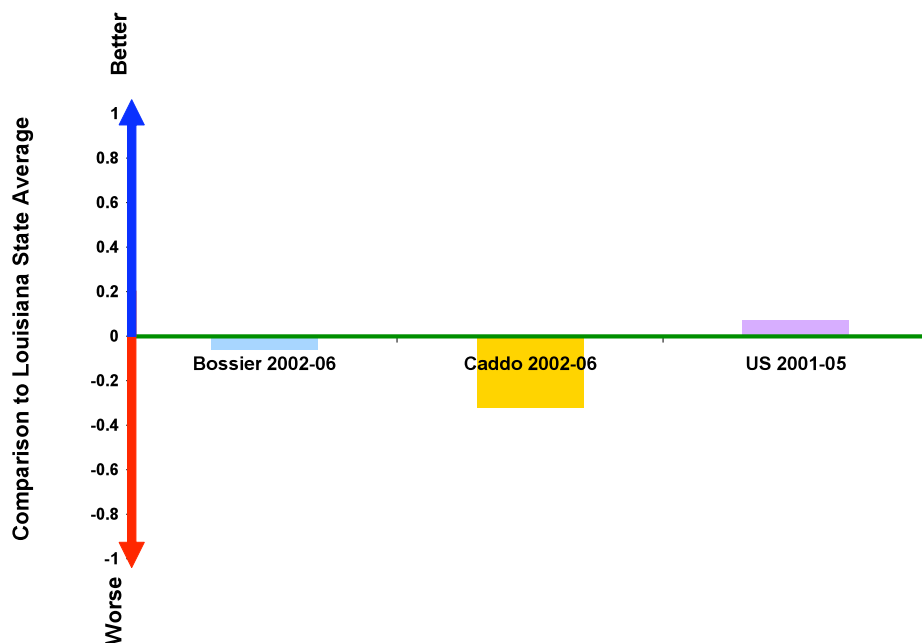
Infant Mortality. Figure 3.2 shows how Caddo and Bossier Parishes compare with Louisiana and the United States on measures of infant mortality. Infant deaths per 1,000 children under one year of age occur more frequently in Caddo Parish than in the state of Louisiana as a whole and in the United States. Caddo

Parish's infant mortality rate is more than 30 percent greater than Louisiana's, a difference large enough for us to classify this as an area of need for Caddo. With about 13 deaths per 1,000 infants each year from 2001 to 2004, Caddo Parish has greater room for improvement in infant mortality than any of the other priority needs listed in this section.

Figure 3.2
Infant Mortality
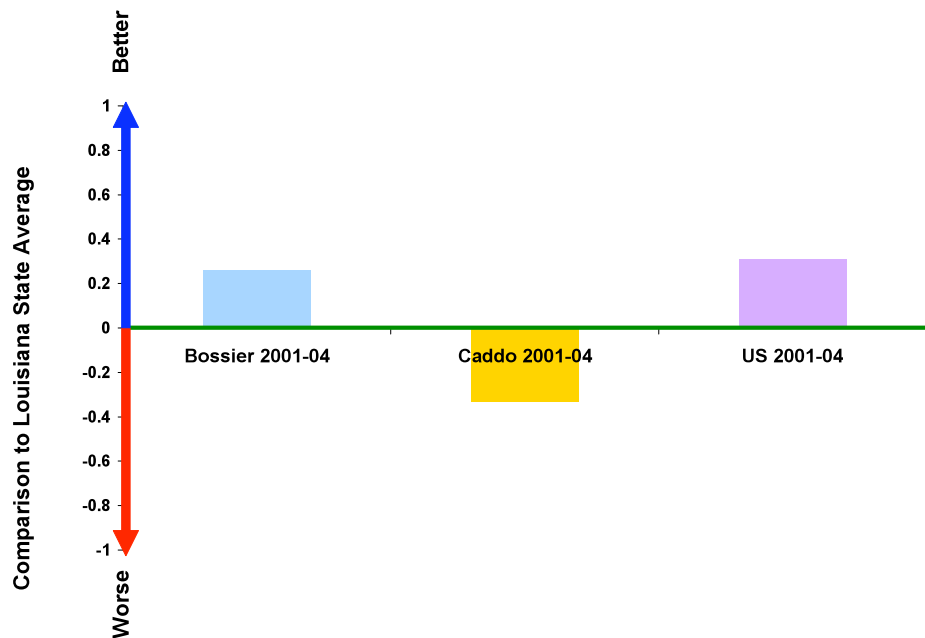
Child Maltreatment

Data for Bossier Parish suggest room for improvement in the areas of child maltreatment. In all three fiscal years for which data was available (FY 2005, FY 2006, and FY 2007), the numbers indicate that Bossier Parish had a higher rate of valid child neglect and abuse investigations per child than Caddo Parish, Louisiana, and the United States. Bossier Parish also reported more Child Protective Investigations per child than Caddo Parish or Louisiana and confirmed a larger portion of these investigations as valid cases.

Because states may differ in their definitions of child maltreatment and may have different policies for handling cases, comparisons of Parish or state figures to the national average may be misleading. One cannot easily determine whether differences are due to policy variations or incidence. However, maltreatment

definitions and policies for reporting and handling cases are the same for all parishes within Louisiana. Therefore, the high number of valid cases in Bossier Parish is likely due to a higher incidence of child maltreatment reports than in Caddo Parish or the state. These reports could reflect higher actual rates of maltreatment, a higher likelihood of maltreatment detection, or a combination of the two. Hence, the higher rates that are reported for Bossier Parish warrant further analysis. While this is beyond the scope of this study, it would be an important next step as the community moves forward on making specific child and family investments.

Child Neglect. Child neglect is the most common form of child maltreatment (U.S. Department of Health and Human Services, 2008). The data for both parishes, Louisiana, and the United States show that child neglect makes up the largest portion of child maltreatment cases. Still, as indicated in Figure 3.3, the incidence of child neglect in Bossier Parish is higher than the average incidence in Louisiana by more than 30 percent. Further, Bossier Parish's rate of valid neglect cases per child more than doubled from FY 2006 to FY 2007. As with physical abuse incidence, future data will show whether this increase is part of a larger upward trend or whether 2007 was an unusual year.

Figure 3.3
Child Neglect

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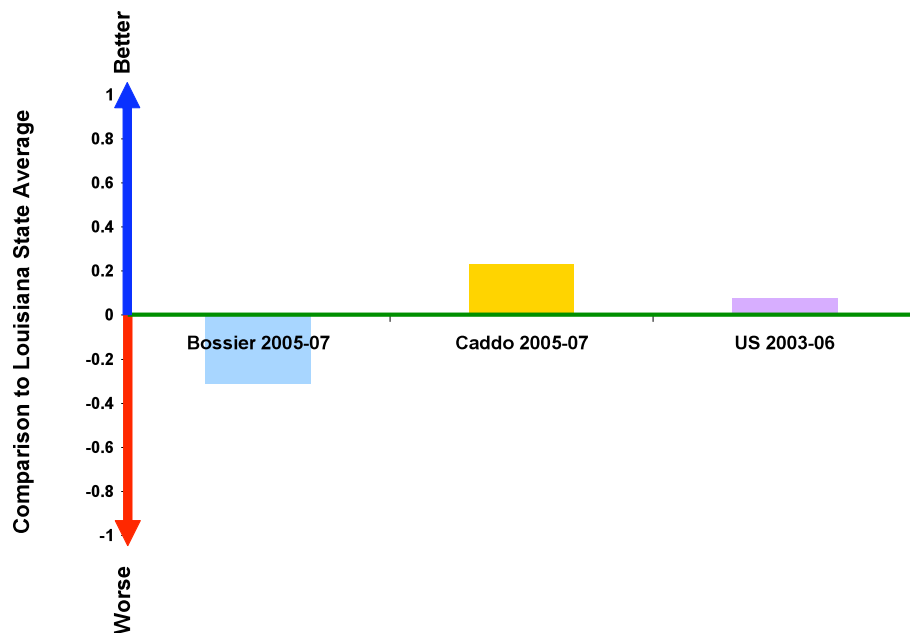
Physical Abuse. Bossier Parish reports a high number of valid physical abuse allegations per child living in its jurisdiction. Figure 3.4 reveals large differences between Bossier Parish's physical abuse rates and those of Louisiana and the United States. Bossier Parish's incidence of physical abuse was 65 percent higher than the state average and 90 percent higher than the U.S. average in FYs 2005 and 2006. In FY 2007, the incidence of physical abuse in Bossier Parish jumped from 1.47 per 1,000 children to 2.08 per 1,000 children. Rates in future years will indicate whether this jump is part of an upward trend or was merely an anomaly in 2007. Caddo Parish had higher rates of physical abuse than both Louisiana and the United States, but the difference was not large enough to be classified this as a high-need area in Caddo Parish.

Figure 3.4
Physical Abuse
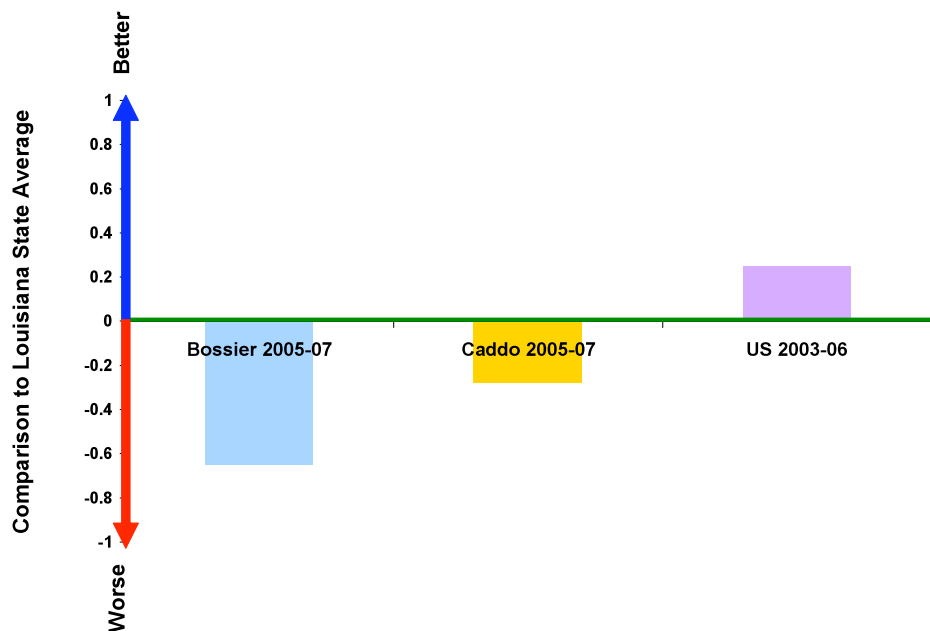
Sexual Abuse. In FY 2005, Bossier Parish reported 74 valid sexual abuse cases. This number is more than twice the cases reported for Bossier in 2006 and 2007 and accounts for the extremely poor performance shown in Figure 3.5. However, Bossier still has a higher average rate of valid sexual abuse cases than Louisiana and the United States even when we examine only FYs 2006 and 2007. Caddo Parish's rates (and numbers) of sexual abuse cases were lower than both Louisiana and the United States.

Figure 3.5
Sexual Abuse
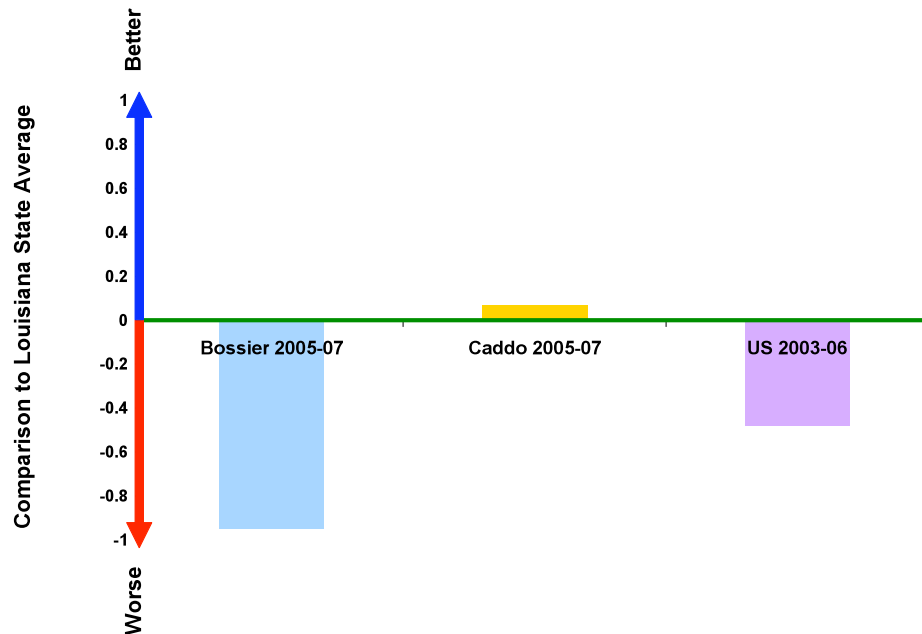
Academic Performance and Educational Attainment

The last three indicators that we've identified as priority need areas fall under the general umbrella of educational attainment and academic performance. Compared with the U.S. national average, Caddo Parish has a higher dropout rate and fewer students demonstrating math proficiency in grades 4 and 8.

Math Proficiency. Figures 3.6 and 3.7 show how the parishes compare with state and national averages in student performance on math tests. Approximately the same percentage of students in Caddo Parish score proficient or above on math tests as in Louisiana, for both 4th and 8th grades levels. Because the tests used to measure national education standards are not the same as the tests used to report county performance, direct comparisons between counties and the United States cannot be made. However average performance in the state of Louisiana is reported for both the national and state tests. Since Caddo Parish performs similarly to Louisiana on state tests, we can presume that Caddo's performance is similar to the state average on national measures as well. Louisiana has a much lower portion of 4th and 8th grade students testing at proficient levels on the national math test than the U.S. average. Thus, it is likely that Caddo Parish

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students are less proficient in math than the average student in the United States. This is also true, although to lesser extent, for Bossier Parish.

Figure 3.6
Math Proficiency, 4th Grade
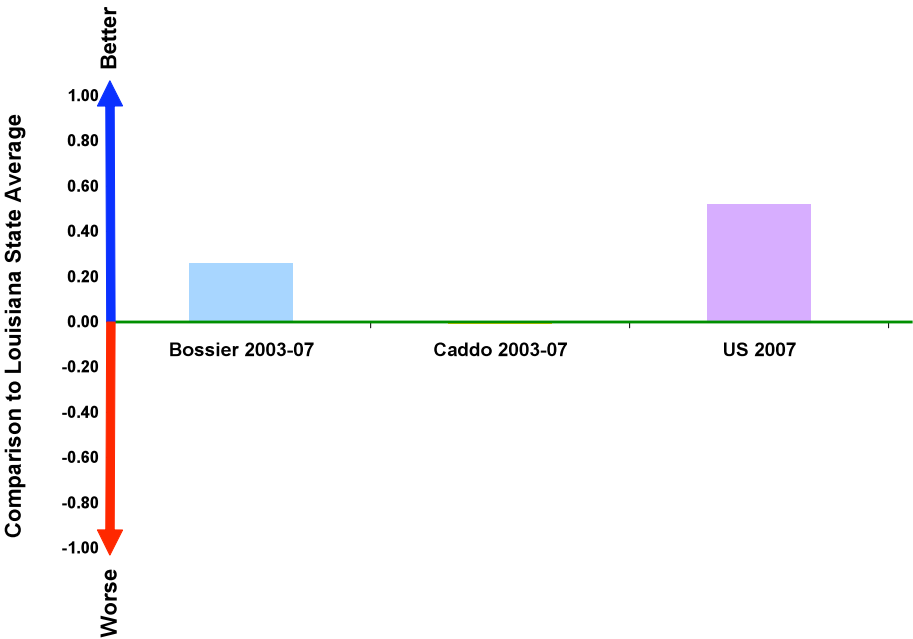
Figure 3.7
Math Proficiency, 8th Grade
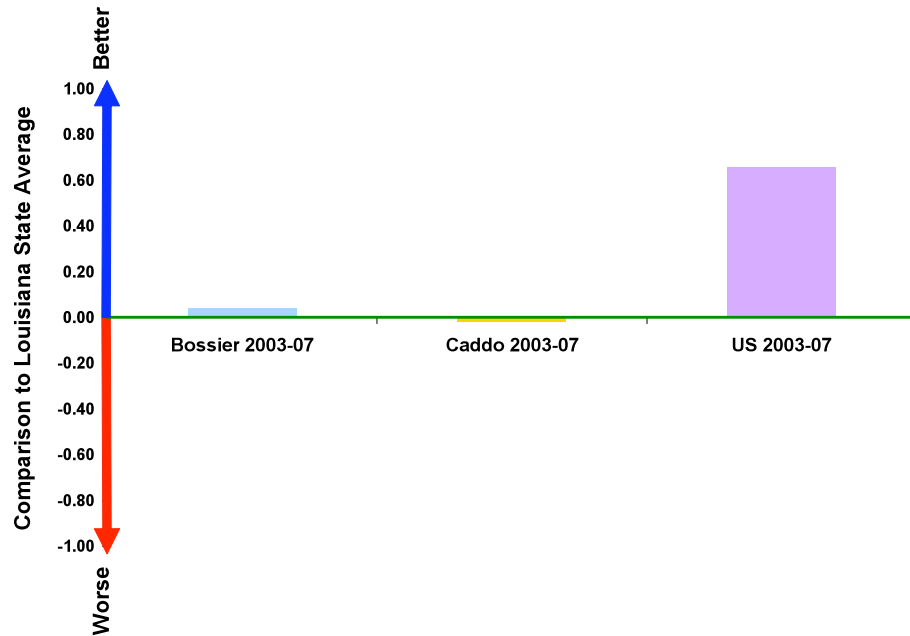
High School Dropout Rate. Caddo Parish has a high portion of high school age children that are not enrolled in high school and have not graduated. On average, about 9 percent of Caddo teenagers were high school dropouts each year between 2001 and 2005. This is 33 percent higher than Louisiana and 53 percent higher than the United States. These differences, shown in Figure 3.8, are large enough to classify dropout rates as a priority need for Caddo Parish. Bossier Parish had a lower portion of dropouts than both Louisiana and the United States.

Figure 3.8
High School Dropout Rates
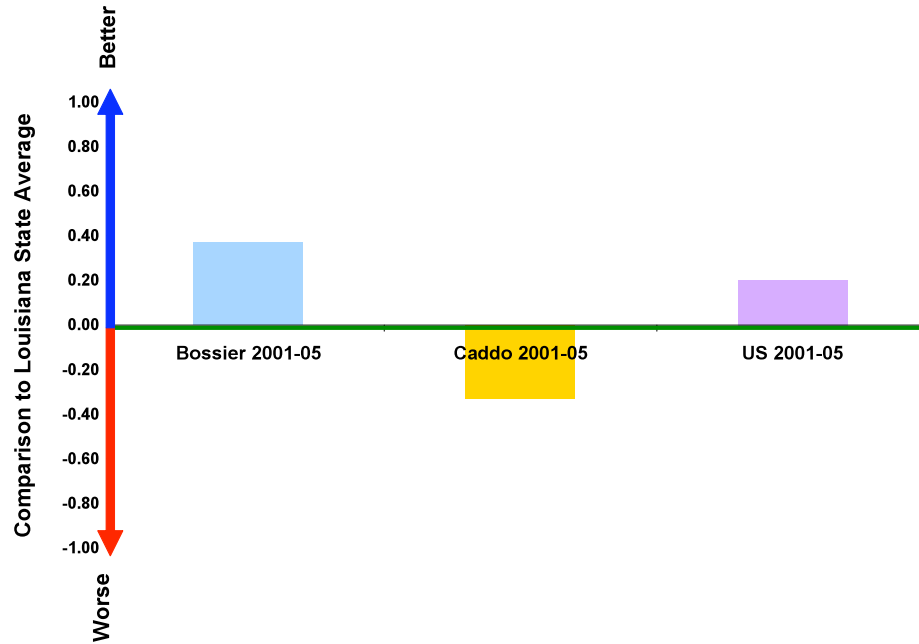
Identifying Assets

This section provides information about the assets that the Shreveport-Bossier area can bring to bear on the priority needs identified in the previous section. Rather than conducting an inventory of every type of asset that might be deployed for all approaches to improving the well-being of children and families, we focus on the assets that are relevant for the priority need areas of infant health, educational attainment, and child maltreatment. As discussed in the previous section, assets may include the skills and time of individuals, private organizational and institutional contributions, and government inputs. Additionally, as discussed in Kretzmann and McKnight (2003), both the quantity and quality of these assets are important. We now review data related to these types of assets to highlight what need areas the region may be in the best position to address.

Volunteers can be a key asset for improving community well-being; in fact, much of the asset mapping literature focuses on the skills and time that individual volunteers can provide (Kretzmann and McKnight, 2003). However, this does not appear to currently be one of the strengths of the Shreveport area. According to *Volunteering in America* data (Corporation for National and Community

Service, 2008), Louisiana ranked 48th among states in terms of volunteer rate. Volunteering was more prevalent in the Shreveport metropolitan area, which includes both Shreveport and Bossier City: Close to 28 percent of area residents reported volunteering, compared with the state rate of 20 percent. The Shreveport area rates of volunteerism are closer to the national average of 27 percent, and volunteers are clearly an important contributor to child and family services. However, these data do not suggest that a high rate of volunteerism is one of the notable assets for this region.

In terms of employment, many of the Shreveport-Bossier area strengths are in areas that are related to human services. Of the top 15 employers in the two parishes in 2006, two were the parish school districts and four were health care providers (Community Foundation of Shreveport-Bossier, 2008). The top employer, in terms of number of employees, was the Louisiana Department of Civil Service, and the second was Barksdale Air Force Base.

The health care sector is one of the leading assets that the two parishes can deploy to improve the priority needs identified above. Shreveport is home to the Louisiana State University Health Sciences Center, which employs nearly 6,000 individuals. In addition to this teaching hospital, three other area medical facilities—Willis Knighton Health System, Christus Shumpert Health System, and Overton Brooks VA Medical Center—employ more than 8,000 people. Although parish-level data are not available on per capita health care workers, state-level data for Louisiana indicate that the state is relatively "rich" in terms of the availability of health care professionals and facilities. The state ranks above the national average, in per capita terms, on number of hospital beds, number of medical school graduates, number of people employed in the health care sector, number of licensed registered nurses, and number of licensed practical nurses (Health Resources and Services Administration, 2009a).

Despite the overall wealth of health care services, data suggest that the distribution of services within the parishes is uneven. The Health Resources and Services Administration (2009a) has designated several census tracts as health professional shortage areas, including Northern Bossier, Northern Caddo, and Central Shreveport. Additionally, the low-income populations in Shreveport are designated as underserved population groups. While the area as a whole has a large supply of health care professionals, it also appears that these professionals are more likely to be located in Caddo Parish than in Bossier Parish (Bureau of Labor Statistics, 2009).

For some of the areas highlighted in the needs assessment, social workers might be another type of professional to tap for services, although we did not identify

data to suggest a large supply of social workers in the area. Parish-level data were not available, and the state data indicate that there are relatively few social workers, per capita, in the state. Furthermore, the largest institution of higher education in the area, the Shreveport branch of Louisiana State University, does not include a social work program. While the social worker workforce does not appear to be a key asset, these findings are not definitive due the paucity of data at the local level.

The education workforce stands out as another area of strength for the region, as it appears that area public school teachers are relatively well paid, many have advanced degrees, and there appears to be positive public support for the schools. Public school attendance rates for both Caddo and Bossier Parishes are higher than the state average, and attendance rates in Bossier Parish have grown since 2000 (Community Foundation of Shreveport-Bossier, 2008). Public school teachers in the two parishes are likely to be a key strategic asset, as they have high rates of advanced degrees and earn salaries higher than the state average (Community Foundation of Shreveport-Bossier, 2008). Furthermore, the majority of residents in a 2008 poll in both parishes gave their local schools either an "A" or a "B" (Community Foundation of Shreveport-Bossier, 2008).

A final asset that we discuss may be one that is sometimes overlooked in the realm of child and family services: Barksdale Air Force Base. The base is recognized as a major employer in the area, but it may be less appreciated as a source of volunteers and a provider of family services. In addition to the nearly 10,000 people who work on Barksdale Air Force Base, there are at least as many family members associated with it. Recent research suggests that military spouses may be underemployed—that is, they are more likely to be unemployed, work fewer hours, and have more education for their position than comparable nonmilitary spouses (Harrell et al., 2004; Lim et al., 2007). This implies that these individuals may be in a position to volunteer or work in the sectors that would promote child and family well-being.

Additionally, military installations are providers of large amounts of family services, ranging from financial literacy programs to programs to combat family deployment stress (Tanielian and Jaycox, 2008; Zellman et al., 2008). Barksdale Air Force Base offers a New Parent Support Program and a Child Development Center with 190 slots for children under age five, as well as numerous other programs (Military HOMEFRONT, 2009). In other words, this employer has demonstrated a commitment to investing in child and family services and has a well-developed infrastructure for doing so. As such, it may already be well positioned to be a partner in developing additional child and family supports.

Best Practices

We now briefly summarize evidence-based practices that have been shown to promote the three high-need topics identified above: infant health, educational attainment, and child maltreatment. The summaries below draw directly from material on the Promising Practices Network website, http://www.promisingpractices.net.

Infant Health[1]

The infant health measures for which the region demonstrates room for improvement—preterm birth and infant mortality—are part of a set of infant health measures that are highly related, including low birth weight (LBW), preterm births (or prematurity), and infant mortality. LBW is defined as birth weight under 5.5 pounds, and LBW may due to prematurity or fetal growth retardation. A premature fetus is generally a normally developing fetus that is delivered before reaching full term. A fetus that experiences growth retardation has lagged in its growth, and even a full-term baby may be LBW. A little more than half of LBW births are due to prematurity (Hediger et al., 2002). When LBW is due to growth retardation, it is generally considered to be a greater risk for poor outcomes than when LBW is due to prematurity (Bartels and Pets, 2008).

The LBW cutoff of 5.5 pounds is considered to be somewhat arbitrary, as successively lower birth weights are associated with worse outcomes in a spectrum of outcomes over a person's life cycle. LBW babies and preterm births are more likely to die in the first year of life and suffer from chronic health conditions, such as asthma and high blood pressure, as well as compromised cognitive development. The disadvantage from poor infant health outcomes persists into adulthood, with lower birth weight individuals scoring lower on IQ tests at age 18, attaining less education, and earning less income than their peers (Black et al., 2007).

There a number of risk factors that are well known to be associated with poor infant health outcomes (Chomitz et al., 1995):

- maternal education less than high school
- teen mother (less than 20 years old)
- low family income
- cigarette smoking, alcohol consumption, and/or cocaine use during pregnancy

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[1] This discussion of best practices in the area of infant health draws heavily on Promising Practices Network (2009f).

- multiple birth
- short maternal stature or low maternal prepregnancy weight
- history of infertility
- single mother
- no or inadequate prenatal care
- perceived maternal stress
- closely spaced pregnancies
- African-American mother
- older mother (more than 35)
- total pregnancy weight gain less than 22 pounds or poor nutrition
- sexually transmitted diseases or other infections
- mother has hypertension or diabetes
- previous delivery of a LBW baby
- mother's physical abnormalities or anomalies
- occupational and environmental exposures
- physical harm from injuries
- sexual activity during late pregnancy
- unwanted pregnancy.

For decades, attempts to improve infant health have focused on prenatal care and smoking cessation. However, a recent review article that examined strategies for addressing the primary two reasons for LBW concluded that "neither preterm birth nor [intrauterine growth restriction] can be effectively prevented by prenatal care in its present form." (Lu et al., 2003). Moreover, the authors of this article rated smoking cessation as only "modestly effective." Similarly, a 2007 Institute of Medicine committee on preterm births declared that "there is no test that can accurately predict a preterm birth and little is known about how a preterm birth can be prevented" (Behrman and Butler, 2007).

Given that contributors to poor infant health include individual, social, community, and environmental factors, it is not surprising that promising approaches to improving infant health include a range of strategies. Evidence-based approaches to promoting infant health generally stress modifiable individual-level factors, such as maternal obesity or stress. Currently, the most promising strategies include (Behrman and Butler, 2007):

- Improving women's general health over the life cycle. This includes improving health conditions, such as diabetes, asthma, and mental illness, that are related to poor birth outcomes.
- Helping women improve fertility planning to reduce unwanted pregnancies and to space births at least 18 months apart.
- Encouraging women to engage in healthy preconception behaviors, such as taking folic acid supplements and identifying pregnancies in a timely fashion.
- Improving the health behaviors of pregnant women, including smoking cessation, reducing or quitting drug use, and appropriate weight gain.
- Screening pregnant women for certain medical conditions, such as infections or physical abnormalities (reprinted with permission from the Promising Practices Network).

Educational Attainment

While math proficiency in 4th and 8th grades were identified as high-need outcomes for the region, we focus the best practices discussion on approaches to raising high school graduation rates. This is because there are relatively few interventions that focus on math skills per se and because raising high school graduation is a goal that is likely to have greater payoffs given its strong relationship with earnings, health, criminal behavior, and the outcomes of an individual's children.

There are numerous approaches to calculating high school completion and dropout rates (see Laird et al., 2008, for example), but, whatever approach you use, the high school completion rate has remained flat in the United States at about 74 percent between 2002 and 2006 (Balfanz and West, 2009), and this rate has also been relatively stagnant for about three decades. At the same time, the earnings premium for higher educated workers has grown dramatically over the last three decades (Mishel et al., 2007).

The primary evidence-based approaches to promoting high school completion involve changes at the school level as well as interventions targeted toward individuals at risk of dropping out. The first of these is to develop data systems that allow schools and districts to accurately monitor rates and trends in overall school dropout and completion numbers and to identify individual students who may be at risk of dropping out (U.S. Department of Education, 2008). This requires schools—and, ideally, states—to create data systems that assign individual student identifiers so that students' absences, grade progression, and academic performance can be regularly monitored. As indicated by the Louisiana Department of Education website (www.louisianaschools.net), the state currently collects dropout information and is in the process of establishing data collection procedures to measure graduation rates at the district level, and it will soon make this information publicly available.

Once children have been identified as being at risk of dropping out, interventions that attempt to promote school retention generally focus on improving behaviors, academic performance, or both. While there are some programs specifically designed to improve specific behaviors, such as problem-solving skills, social interaction, and decisionmaking, many approaches to improving behaviors focus on relationships. The latter include mentoring programs, teaming students with counselors who regularly meet with them, and placing at-risk students in smaller classrooms where there the learning environment is more personalized and teachers get to know students better (Promising Practices Network, 2009h; U.S. Department of Education, 2008).

Other individual-level interventions focus more on enrichment to promote academic performance, possibly in tandem with behavioral interventions. These may include intensive instruction in particular subjects or personalized instruction.

In other cases, successful attempts to promote high school graduation have been implemented schoolwide rather than just for students identified as being at risk of dropping out (Dynarski and Gleason, 1998). These interventions tend to include the same strategies as the individual approaches—smaller classes, more personalized instruction, establishing close relationships with an adult, and academic enrichment—but at the whole school or classroom level (National Governors Association, 2005).

In sum, at the school-wide level or targeted toward students at risk of dropping out, these strategies have been shown to promote high school completion:

- mentoring or counseling of middle and high school students

- smaller classes or more personalized learning environments in which students develop closer relationships with teachers and other adults

- interventions that improve behaviors through building skills in such areas as problem solving, interpersonal relationships, and decisionmaking

- intensive academic enrichment and individualized instruction

- data systems that facilitate accurate accounting of district- and schoolwide rates and trends and also facilitate the identification of students at risk of dropping out.

Child Maltreatment[2]

Infants are the highest risk of child maltreatment, with nearly one-quarter of the victims of child abuse and neglect being under one year old (U.S. Department of Health and Human Services, 2008). The overwhelming majority (83 percent) of perpetrators are parents, and the most common form of maltreatment is neglect, with about two-thirds of maltreatment cases being neglect (U.S. Department of Health and Human Services, 2008). Neglect includes such activities as being

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[2] This discussion of best practices in the area of child maltreatment draws heavily on Promising Practices Network (2009e). We are indebted to Rebecca Shaw for her input into this section.

unable to care for a child due to incapacitation from controlled substances or failing to provide a child with needed food or medical care.

Approaches to preventing child abuse and neglect typically seek to prevent the risk factors associated with child maltreatment, to put protective factors in place for children and families, or to strengthen protective factors that are already present in children's lives. *Primary prevention* strategies are universal, reaching the entire population, while *secondary prevention* strategies target at-risk groups. *Tertiary prevention* strategies serve families in which abuse has previously occurred. Examples of promising practices include

- public awareness and education

- skill-based curricula or life skills training for children and youth

- parent education programs

- home visitation programs

- family support services including respite or crisis care.

We now briefly review primary prevention approaches, and then secondary prevention approaches.

Public awareness activities are one of the more common approaches to preventing child abuse and neglect. These involve communicating to a broad audience through such vehicles as public service announcements, information kits and brochures, and TV/other media content. These messages tend to promote positive parenting practices and inform the public about what steps to take when maltreatment is suspected (U.S. Department of Health and Human Services, 2003a).

Rather than measuring the effect of public awareness activities on preventing child abuse and neglect per se, most evaluations of public awareness activities have measured exposure to the campaign or activity (e.g., telephone surveys asking community members whether they remembered seeing campaign materials) or the increase in contacts made to the campaign sponsor or designated prevention organization (e.g., increased calls made to prevention and reporting hotlines). For instance, an evaluation of a multimedia campaign to promote awareness and understanding of the link between addiction and child abuse was associated with a 62 percent increase in the average monthly number of calls made to telephone hotline for child abuse and neglect. However, the impact on abuse and neglect outcomes was not assessed (Andrews et al., 1995).

Some of the most studied public education and awareness campaigns related to child abuse and neglect have been those focused on preventing shaken baby syndrome. Public awareness campaigns related to shaken baby syndrome first appeared in the 1980s, and the National Center on Child Abuse and Neglect (NCCAN) spread the message "Never Shake a Baby" in a more organized, national effort that began in 1992. An evaluation of NCCAN's three-year campaign reported that one-third of people who gave feedback on the educational materials indicated that this was the first time they had received information on shaken baby syndrome (Showers, 2001).

Another approach that has been widely employed involves programs that are for at-risk children or all children and use skill-based curricula. These curricula teach children skills they can use to keep themselves safe, such as being able to distinguish whether they have been touched appropriately or inappropriately and what they should do if they experience the latter. For example, the Safe Child Program is a skill-based curriculum for children designed to prevent sexual, emotional, and physical abuse. Evaluations of the Safe Child Program found that it taught children skills that helped them avoid being victims, such as how to speak up for themselves, how to recognize dangerous situations or inappropriate behavior by other people, and knowing where and how to get help (see the Promising Practices Network description of the Safe Child Program [Promising Practices Network, 2009g]).

A related prevention strategy is parent education programs, which help parents learn appropriate discipline techniques and become more knowledgeable about age-appropriate behavior and expected developmental milestones. Many parent education programs also assist parents in learning how to identify community resources that provide support and assistance to families, such as counseling services or economic resources.

Parent education programs may be embedded in more general child and family services setting or stand alone. An example of a program that is embedded in a more general children's program is the Chicago Child-Parent Centers (Promising Practices Network, 2009a), which includes enriched preschool, home visiting, and referrals of families to social services. An evaluation of this program (Reynolds et al., 2001) that followed children for 15 years found that significantly fewer children who attended the program in preschool were the subjects of child maltreatment reports, compared with children who had not been in the program. An example of a stand-alone parent education program that focuses on child abuse and neglect prevention is the Period of PURPLE Crying, which attempts to prevent shaken baby syndrome by helping parents understand and cope with the stresses of normal infant crying. A randomized control trial of the program

found that, relative to control group mothers, mothers who participated in the program were more likely to walk away in situations in which an infant was crying inconsolably. The program also increased mothers' knowledge about infant crying (Barr et al., 2009).

The CDC recently undertook a meta-analysis on parent training programs for parents with children age 0–7 (Centers for Disease Control and Prevention, 2009). This study identified specific components within the parent training programs that were associated with improvements in parenting skills and behaviors and declines in children's externalizing behaviors. Table 3.1 lists these components.

Table 3.1

Program Components Associated with Effective Parent Training

Outcome	Program Component
Acquiring parenting skills and behaviors	Teaching parents emotional communication skills *(content component)*
	Teaching parents positive parent-child interaction skills *(content component)*
	Requiring parents to practice with their child during program sessions *(program delivery component)*
Decreases in children's externalizing behaviors	Teaching parents the correct use of time out *(content component)*
	Teaching parents to respond consistently to their child *(content component)*
	Teaching parents to interact positively with their child *(content component)*

	Requiring parents to practice with their child during program sessions *(program delivery component)*

SOURCE: Promising Practices Network (2009e), adapted from Centers for Disease Control and Prevention, 2009.

There are also a number of secondary prevention approaches that target children and families with risk factors for abuse. These include home visitation programs, respite and crisis care programs, and family resource centers.

Home visitation programs generally provide information about child development and healthy parenting practices and also provide social support for pregnant women and families with new or young children. Two home visitation programs have been shown to reduce child abuse by parents in randomized control trial evaluations: Nurse Family Partnership and Healthy Families New York. For instance, in a nine-year follow-up study, Olds et al. (2007) found that children whose mothers participated in the Nurse Family Partnership died less frequently of preventable causes. Similarly, a recent evaluation of Healthy Families New York (DuMont et al., 2008) reported that young, first-time mothers in the program were less likely at the time their children were two years olds to engage in minor physical aggression in the past year (51 percent versus 70 percent) and harsh parenting in the past week (41 percent versus 62 percent), compared with a control group of mothers not in the program. Furthermore, the evaluation of the Healthy Families New York program also found that mothers who participated in the program, including "psychologically vulnerable" mothers, committed one-quarter as many acts of serious abuse when the child was two years old, compared with the control group. (See Promising Practices Network descriptions of the Nurse Family Partnership [Promising Practices Network, 2009d] and Healthy Families New York [Promising Practices Network, 2009b].)

Respite and crisis care and family resource centers are also provided in order to reduce child maltreatment. Respite and crisis care services offer families in crisis short-term urgent services. Family crises may arise because of family illness or other emergencies. Respite or crisis care may provide a temporary place where the child can be cared for when a caregiver is overwhelmed with stress or when caregivers of children in the child welfare system need assistance with caregiving. Family resource centers generally offer a variety of services to families, including parent skill training, job training, substance abuse prevention, mental health or family counseling, and financial support services (e.g., meeting basic needs, housing). The services offered by the centers often reflect the needs

of local families. Despite the popularity of these two approaches, the evidence of their effectiveness in preventing child maltreatment is weak.

There are also several studies that have synthesized existing studies of child maltreatment prevention programs. One meta-analysis (Lee et al., 2008) found evidence that several prevention programs were effective and that the benefits of some of the programs exceeded their costs. An older meta-analysis (Abt Associates, 2001) reported relatively small effects of a range of family support programs on child abuse and neglect outcomes.

PPN presents overviews of several programs that have been rigorously evaluated and found to have a positive impact on preventing child abuse and neglect (Promising Practices Network, 2009h). PPN has also reviewed several compendia that provide evidence-based information about programs that have been found to prevent child abuse and neglect, or mitigate its consequences. Two of the compendia that use rigorous evidence criteria are Child Trends' LINKS (Child Trends, 2009) and the U.S. Department of Health and Human Services *Emerging Practices in the Prevention of Child Abuse and Neglect* (U.S. Department of Health and Human Services (2003b).

4. Recommendations: The Intersection of Needs, Assets, and Best Practices

We proposed a framework for identifying the priority investments in children and families in the Shreveport-Bossier area that would take advantage of the strengths of needs assessment, inventorying assets, and using evidence-based best practices. The priority investment areas would be those in the intersection of needs, assets, and best practices.

This analysis identified three priority **areas of need** for children and families in the Shreveport-Bossier City area:
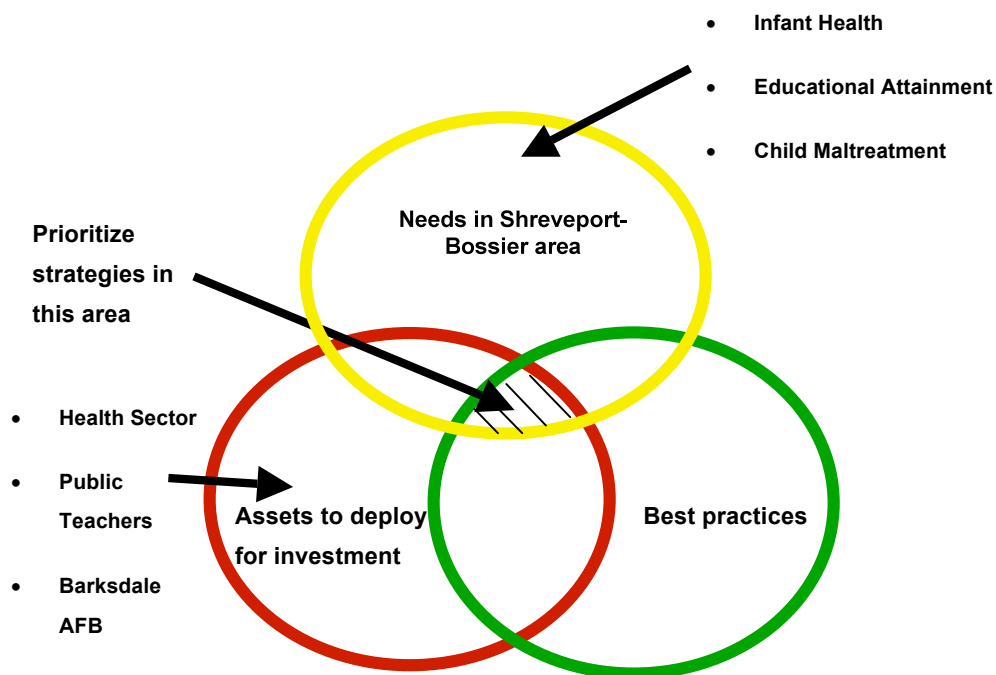
- infant health

- educational attainment

- child maltreatment.

The **strongest assets** in the area that may represent opportunities for improving the well-being of children and families include these resources:

- large quantity of health care facilities and health care providers

- public school teachers and schools

- Barksdale Air Force Base.

Finally, **evidence-based research** indicates that there are a number of effective strategies to improving the areas of need. As shown in Figure 4.1, we focused on strategies that are effective in improving the areas of need—infant health, educational attainment, and child maltreatment—and would draw on the region's strongest assets—the health sector, public teachers, and Barksdale Air Force Base. Table 4.1 lists specific strategies that are at the intersection of these areas of need and resources. Each cell of the table lists evidence-based strategies that address the corresponding need at the top of the column and take advantage of the area resource listed at the beginning of that row.

Figure 4.1
Evidence-Based Strategies Are Those That Address Identified Needs and Draw on Community's Assets

While the strong health care sector can serve as a leader in implementing the evidence-based strategies related to improving infant health outcomes (see list in Table 4.1), another strategy identified for infant health is also a promising approach to preventing child abuse and neglect. As discussed above, there are home visiting and parenting education models that have been shown to promote infant health as well as prevent child abuse and neglect (see www.promisingpractices.net).

Public schools and teachers are in a position to implement evidence-based approaches to addressing all three of the high-need areas in the region. Again, while it is clear that this sector can play the key role in promoting high school graduation, public schools and teachers can also be key contributors to improving infant health and preventing child abuse and neglect. Schools engage in a large amount of public health education, and they are in a particularly good position to educate young women about the importance of maintaining their general health, not only for their own benefit over their entire lifetime but also to improve the outcomes of their children. Helping women begin to engage in good health practices in this period of their lives will help ensure better preconception health.

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Table 4.1

Evidence-Based Strategies at the Intersection of Region's Needs and Assets

Assets	Area of Need		
	Infant Health	**Educational Attainment**	**Child Maltreatment**
Health care facilities and providers	- Improving women's preconception and interconception health - Pregnancy screening and healthy pregnancy behaviors - Parent education and home visitation programs		- Parent education and home visitation programs
Public schools and teachers	- Educating young women on preconception and interconception health	- Mentoring, counseling - Smaller group settings and personalized instruction - Interventions emphasizing behavioral change - Academic-focused intensive programs - Data systems to monitor trends and identify at-risk students	- Skill-based curricula or life skills training for children and youth
Barksdale Air Force Base	- Same approaches as in health care sector - Train spouses to provide education and home visiting services	- Provide mentors for preteens and teens	- Base awareness campaigns - Parent education and home visitation programs

While infants are the most commonly maltreated group of children, there is evidence that programs implemented during the school years can help reduce child maltreatment at older ages. Schools can educate children and provide them with the skills that can help them identify and respond to threats to their safety or potentially neglectful situations.

Our suggesting that Barksdale Air Force Base could be a key partner in the region's quest to boost child and family well-being may be somewhat unexpected entry. In addition to the volunteer and leadership roles from enlisted members, the base may also be a source of highly motivated and educated spouse volunteers, mentors, and members of the family service workforce. Moreover, the base is already providing a large amount of family services, such as new parent education, and it has a great deal of experience in undertaking awareness campaigns for members in areas such as family stress and healthy behaviors.

We have argued that prioritizing strategies that lie in the intersection of need, assets, and best practices can raise the likelihood that investments in children and families produce gains. However, identifying strategies with a high probability of success is only the first step in the process of raising the well-being of children and families. To further the foundation's goals of making successful investments in the priority areas identified by this report, we recommend that the community consider the following specific recommendations for next steps in its investment effort. First, the community may want to create "working groups" to focus on individual types of investments. These might take the form of a diverse set of stakeholders with an interest in particular areas. These could be organized around the priority indicator areas (infant health, school completion, and child maltreatment) or around mobilizing the community assets (health care sector, public school workforce, or Barksdale Air Force base assets). These working groups could also continue to monitor the indicators presented in this report.

Second, these working groups or other entities can determine specific practices, programs, and policies that can best improve the priority investments identified in this report. This report has provided a broad overview of the types of intervention strategies that evidence shows improve the priority areas, but refinement of these strategies is an important next step. As described in Chapter Two, there are a number of frameworks that have been demonstrated to promote successful implementation of evidence-based programs for communities that have already identified their priority areas. These include Getting To Outcomes, Communities That Care, SAMHSA's Strategic Prevention Framework, and others.

The findings from this report represent the first step in the process of using data, research evidence, and strategic planning to identify the areas of child and family outcomes in which the Community Foundation's investments are likely to have the most impact. The success of the investments depends critically on effective implementation. To realize the promise that these priorities offer will require community buy-in, careful planning, faithful replication of evidence-based approaches, and ongoing monitoring.

Appendix A. Other Needs Assessment Graphs

Figure A.1
Students' Proficiency in English Language
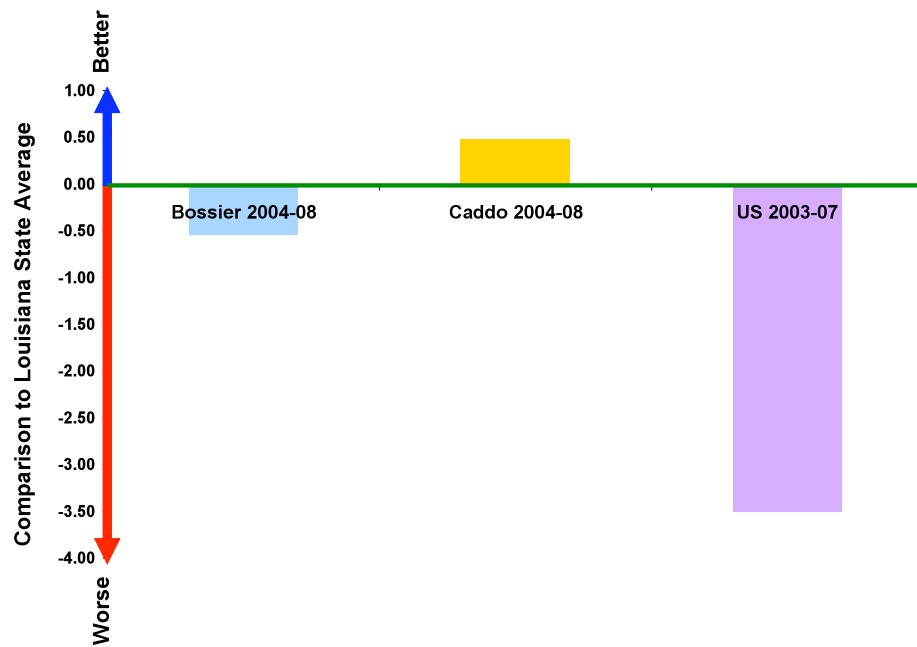
Figure A.2
Portion of Median Income Needed to Cover the Cost of Infant Child Care
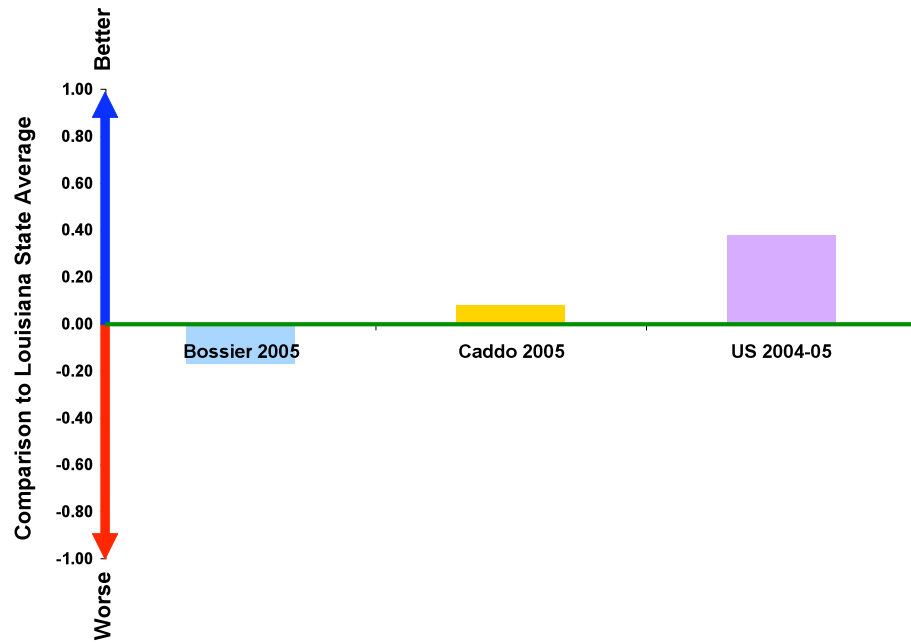
Figure A.3
Pre-Kindergarten Enrollment
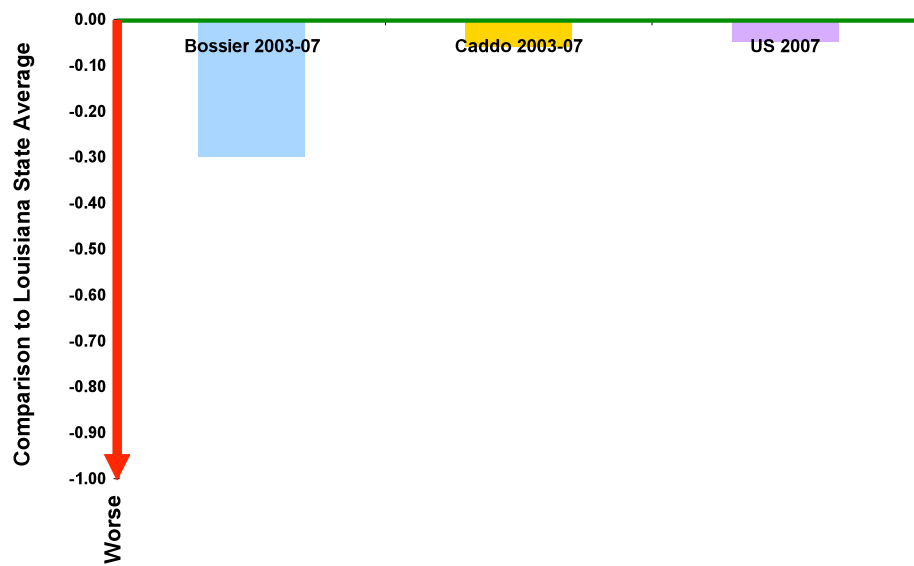
Figure A.4
Babies Born Weighing Less Than 2,500 Grams
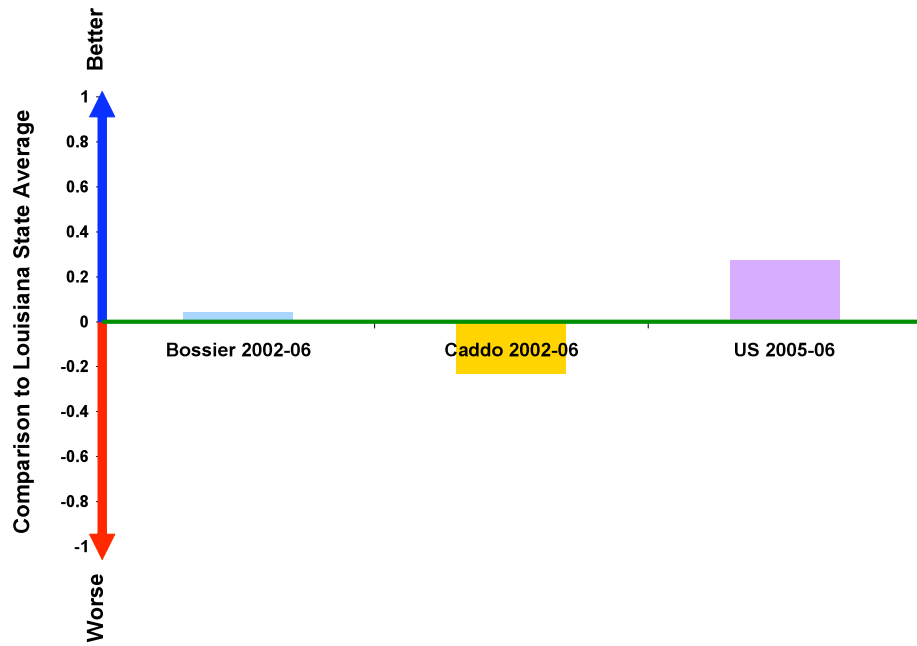
Figure A.5
Portion of Population Living Below Federal Poverty Level
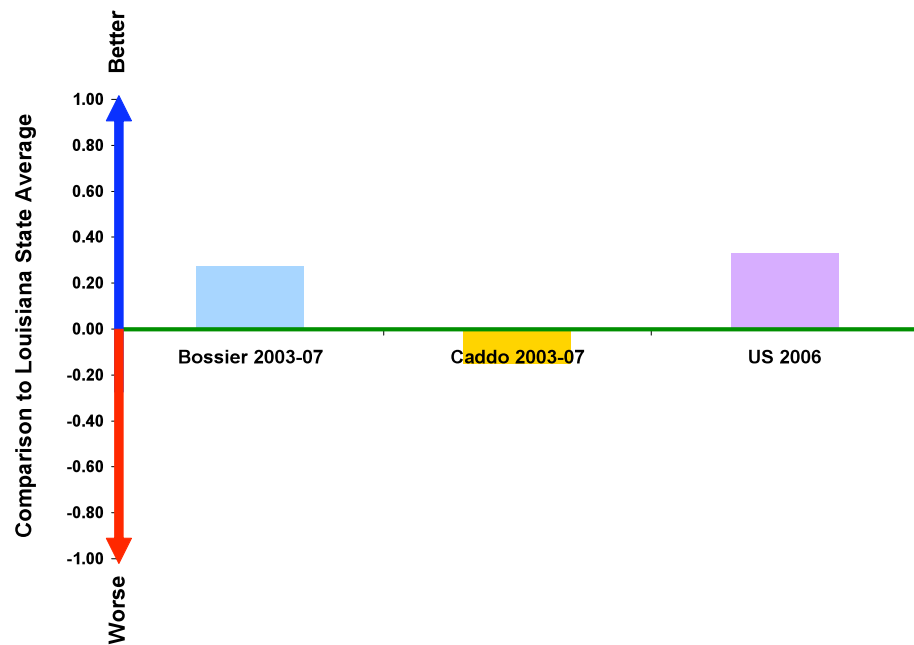
Figure A.6
Portion of Children in Families Living Below Federal Poverty Level
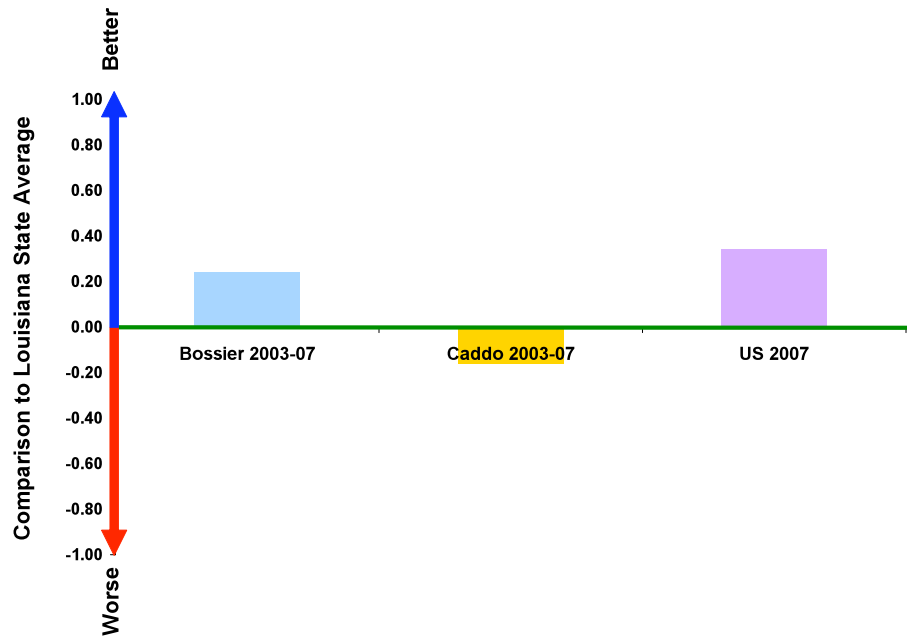
Figure A.7
Portion of Labor Force That Is Unemployed
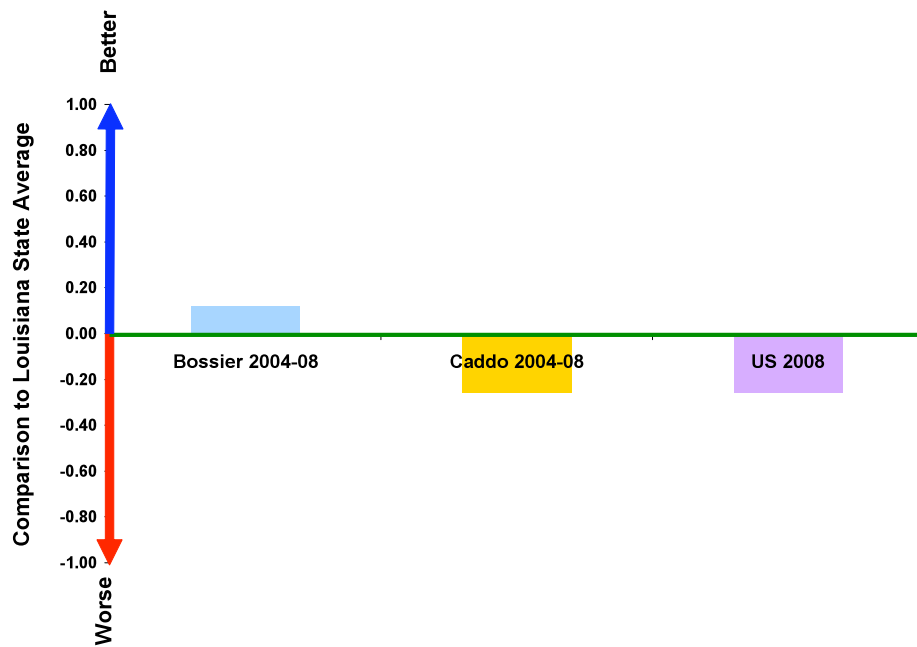
Figure A.8
Portion of Children in Poverty That Receive Food Stamps
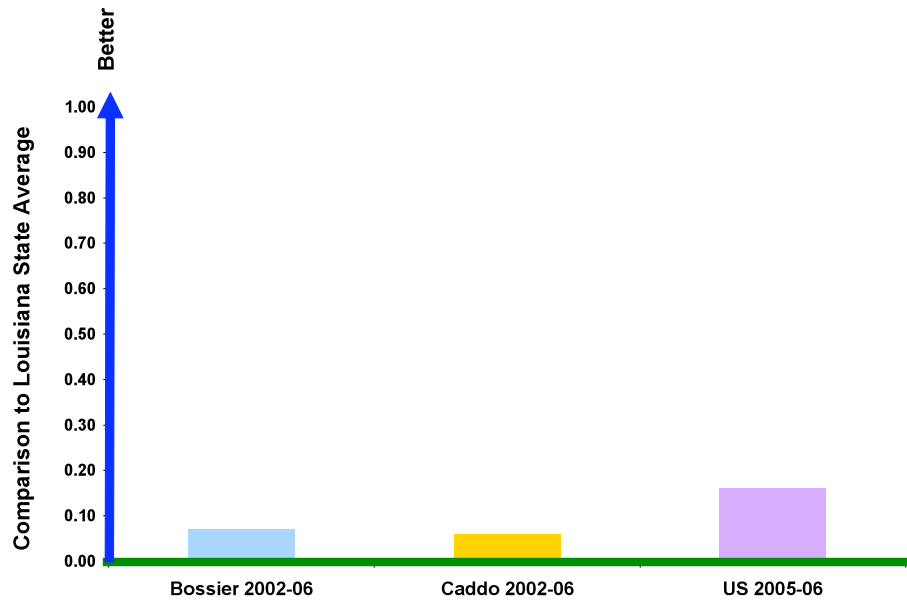
Figure A.9
Median Household Income
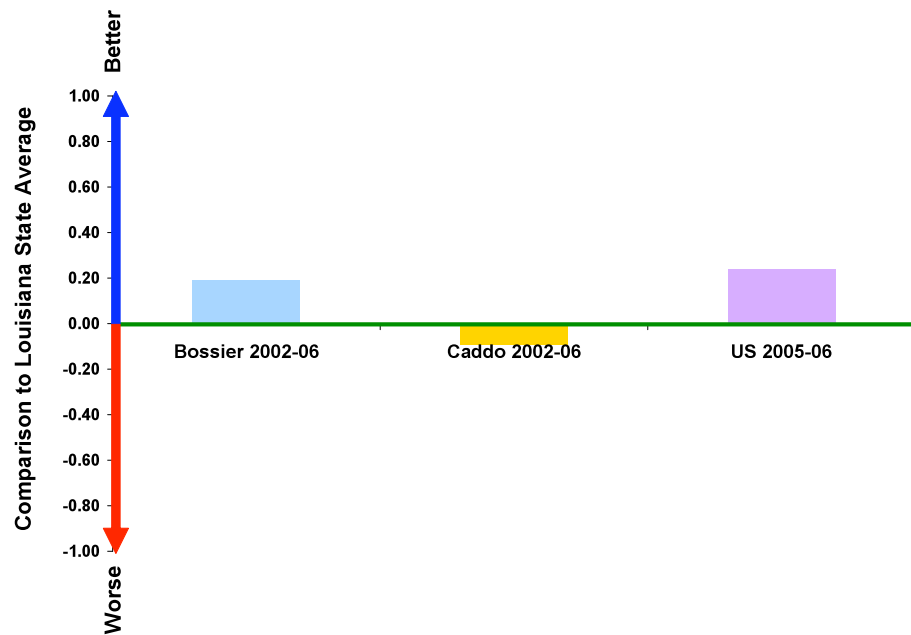
Figure A.10
Students in Families That Qualify for Free or Reduced Price Lunch
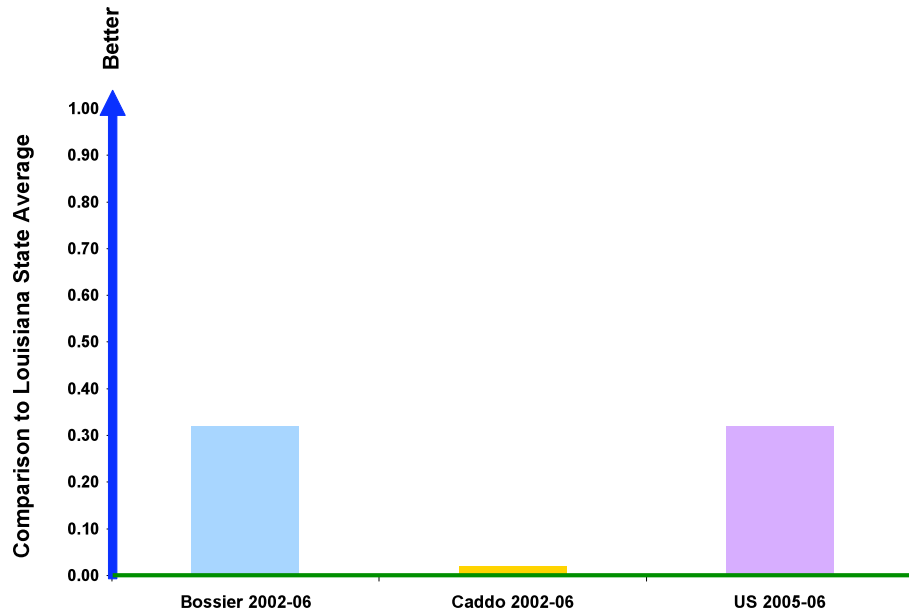
Figure A.11
Portion of Population in Poverty That Received EITC
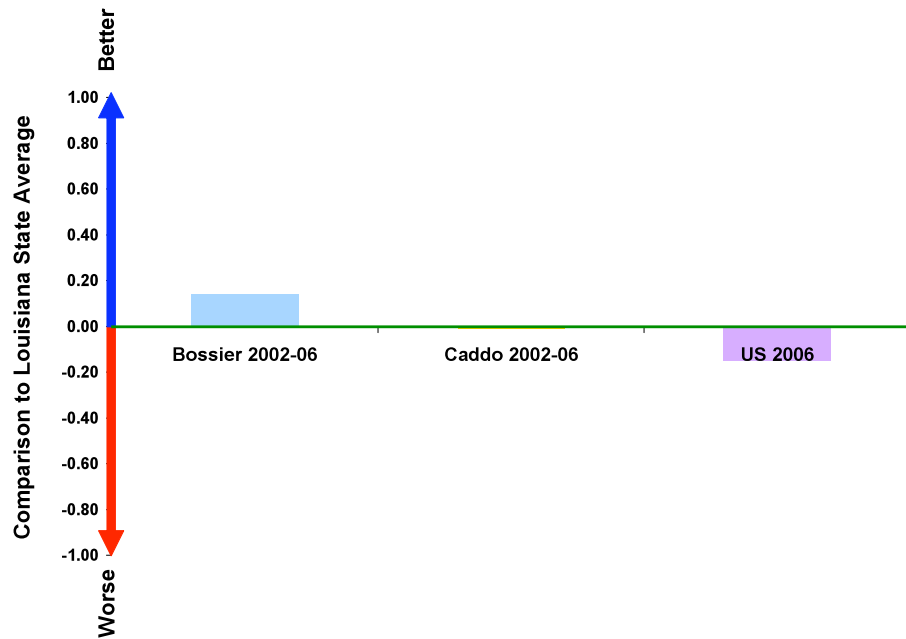
Figure A.12
Portion of Children in Poverty Enrolled in Medicaid
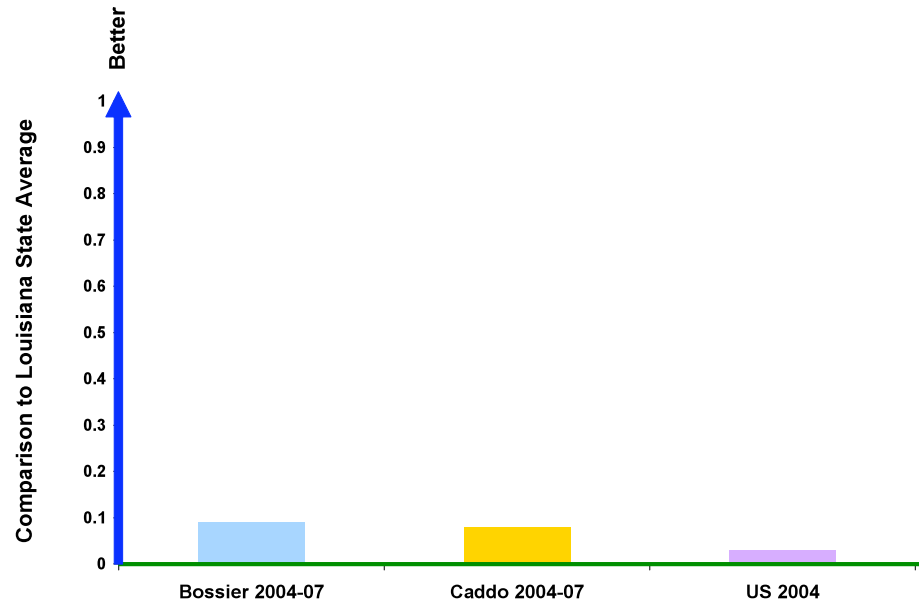
Figure A.13
Babies Born to Teenage Mothers
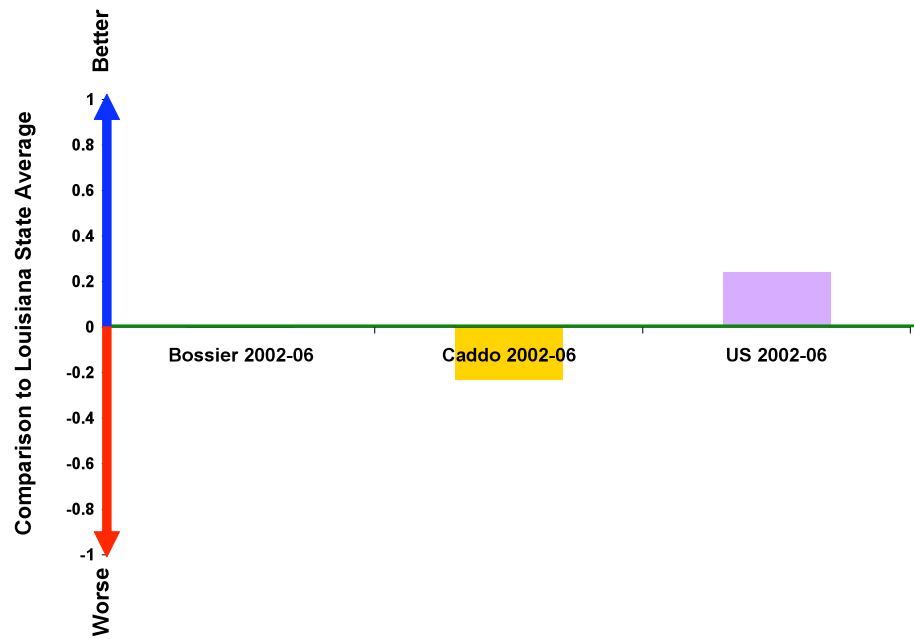
Figure A.14
Portion of Children Current on Immunizations at 24 Months
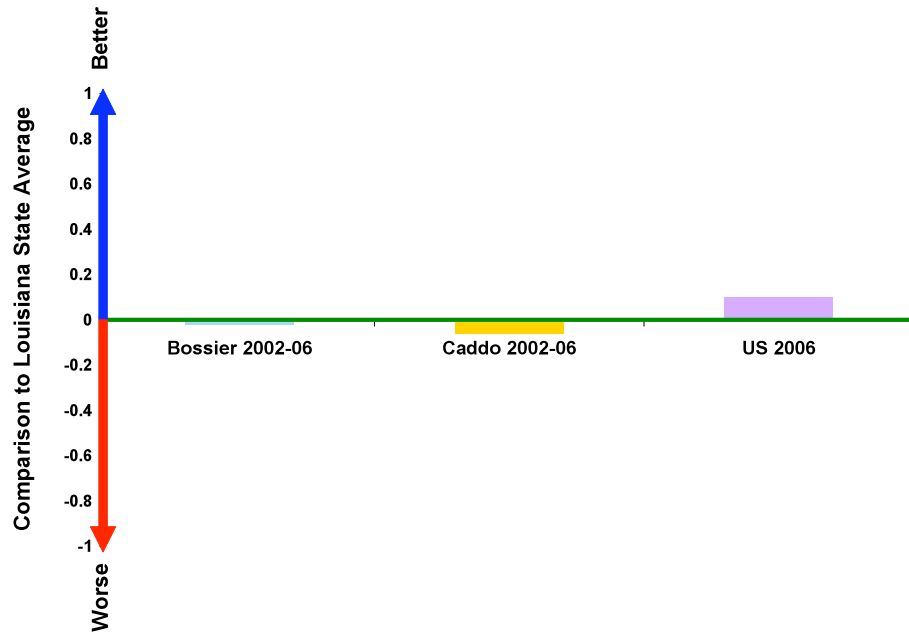
Figure A.15
Babies Born to Mothers Who Received Early and Adequate Prenatal Care
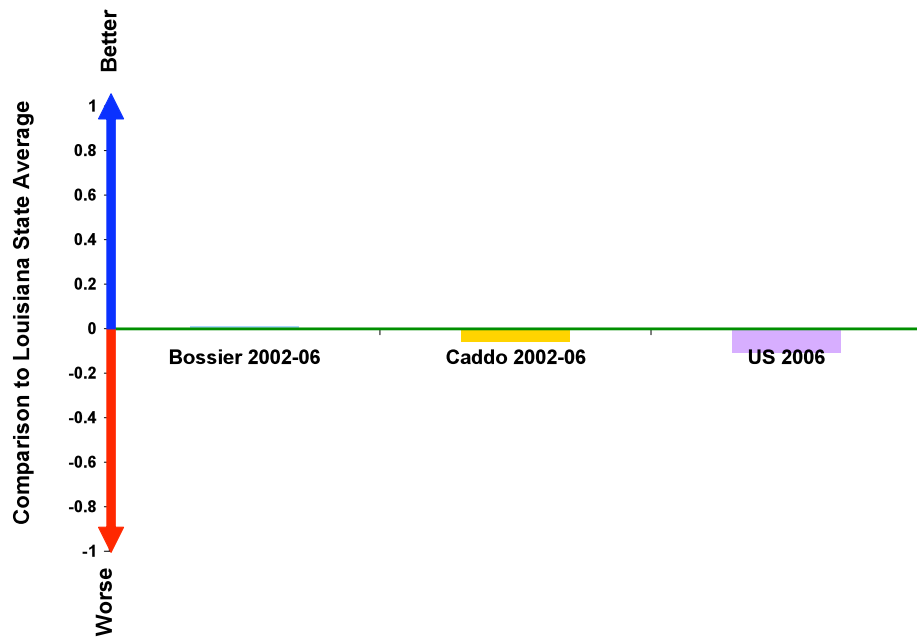
Figure A.16
Portion of Children Not Covered by Health Insurance
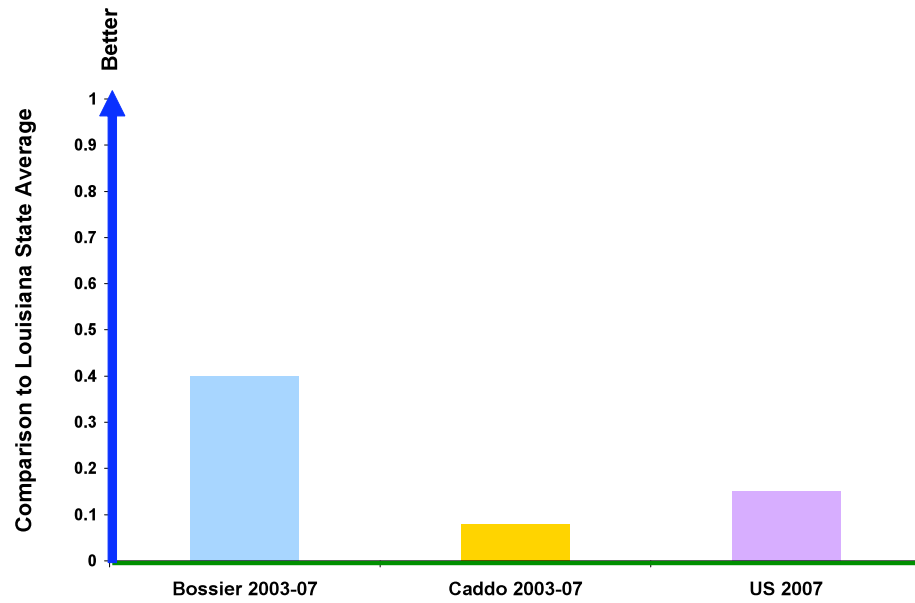
Figure A.17
12th Graders Who Reported Smoking at Least Once in 30 Days
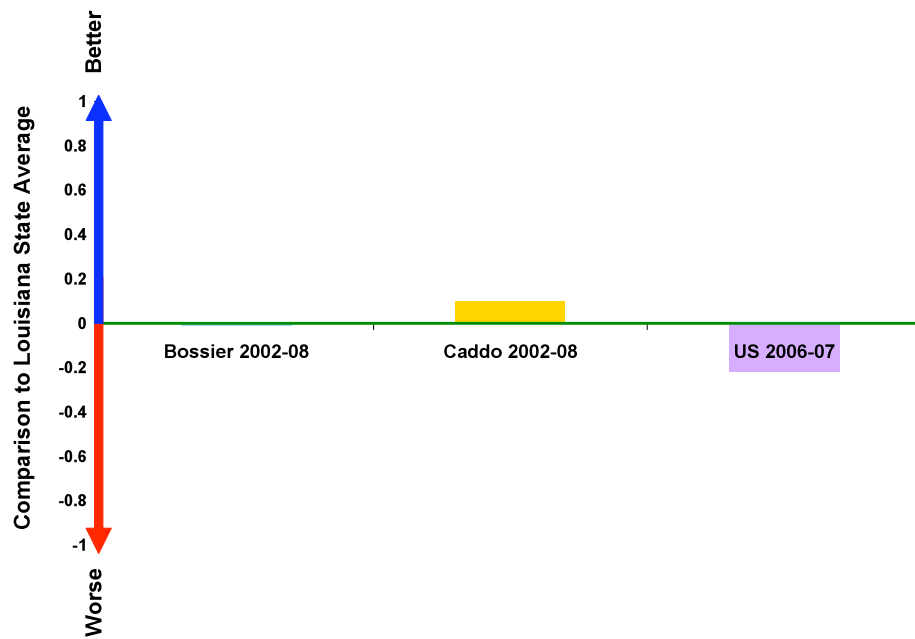
Figure A.18
12th Graders Who Reported Binge Drinking Behavior
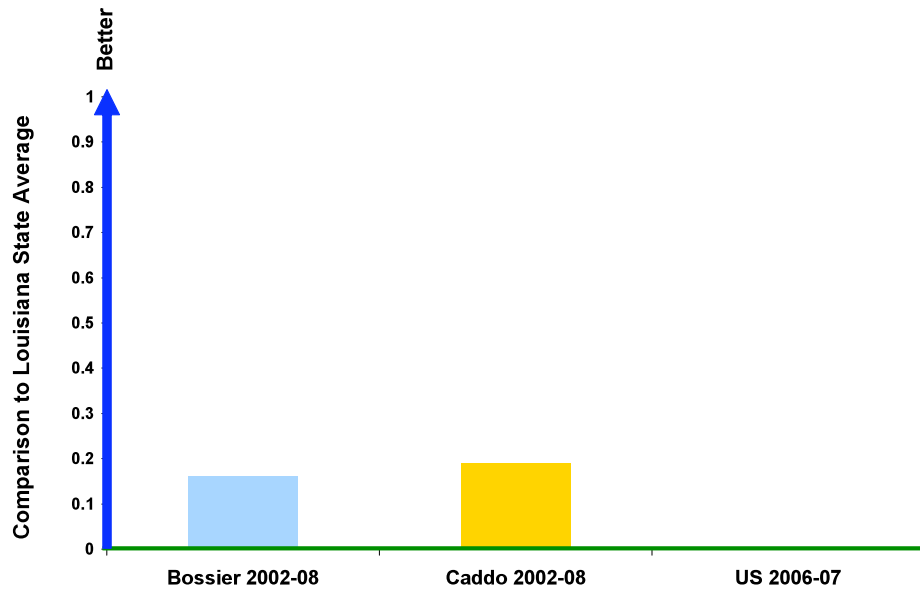
Figure A.19
8th Graders Who Reported Binge Drinking Behavior
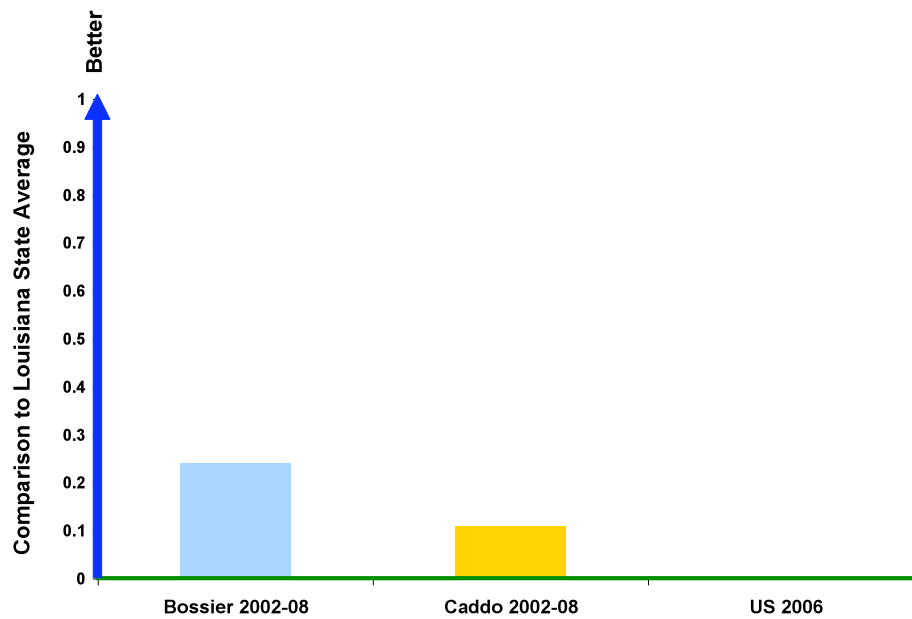
Figure A.20
Average Teacher Salary in Public Schools
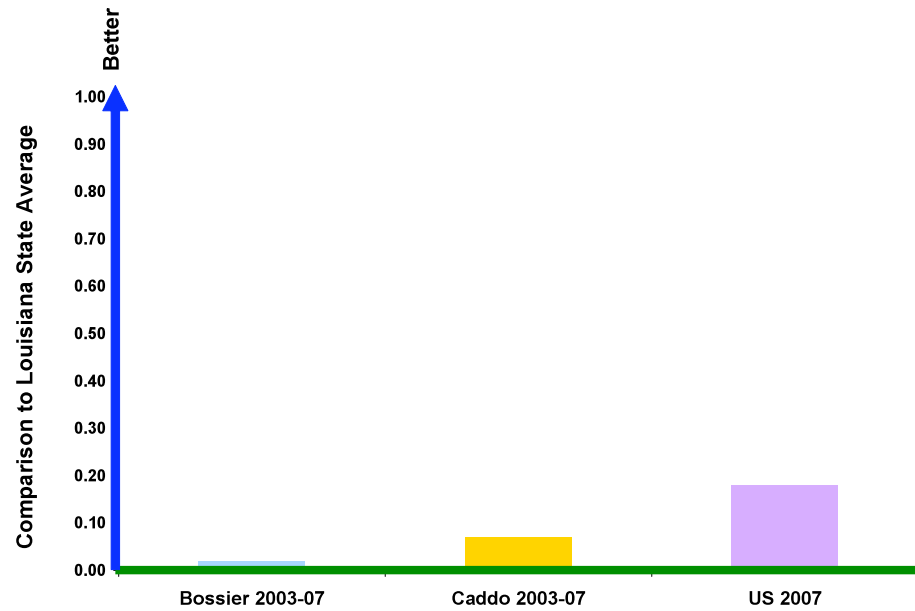
Figure A.21
English Language Arts Proficiency, 8th Grade
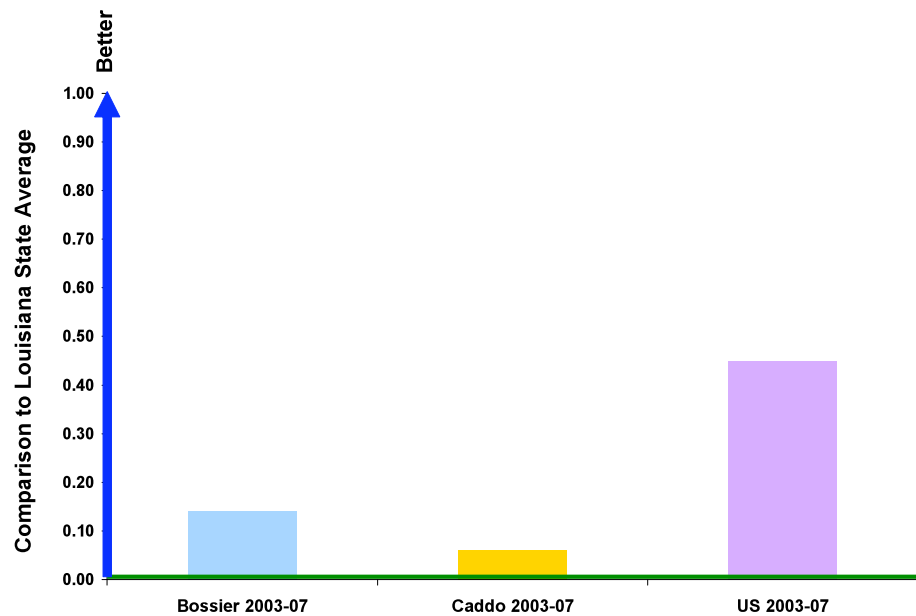
Figure A.22
English Language Arts Proficient, 4ᵗʰ Grade
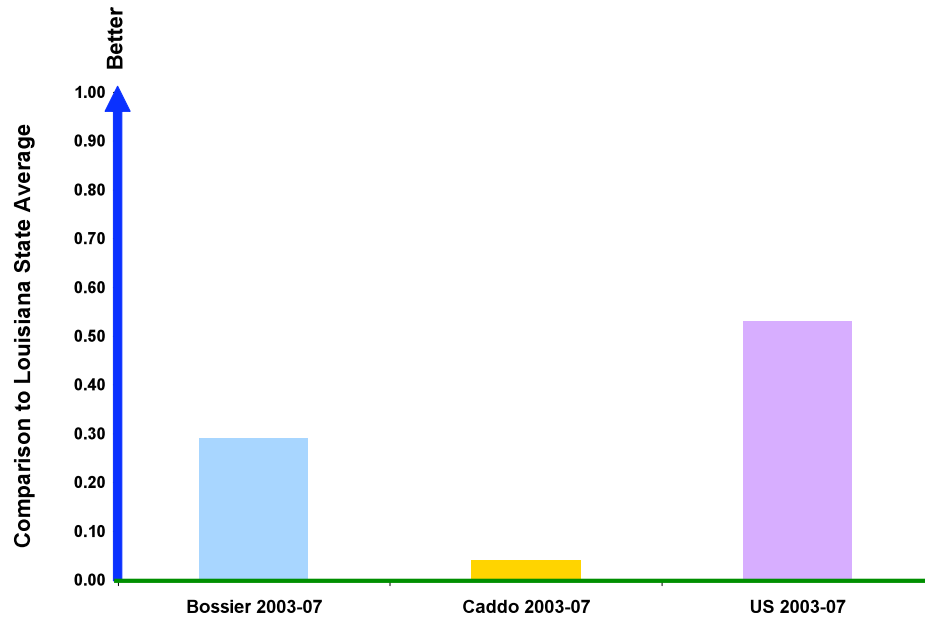
Figure A.23
Public School Faculty with a Master's Degree
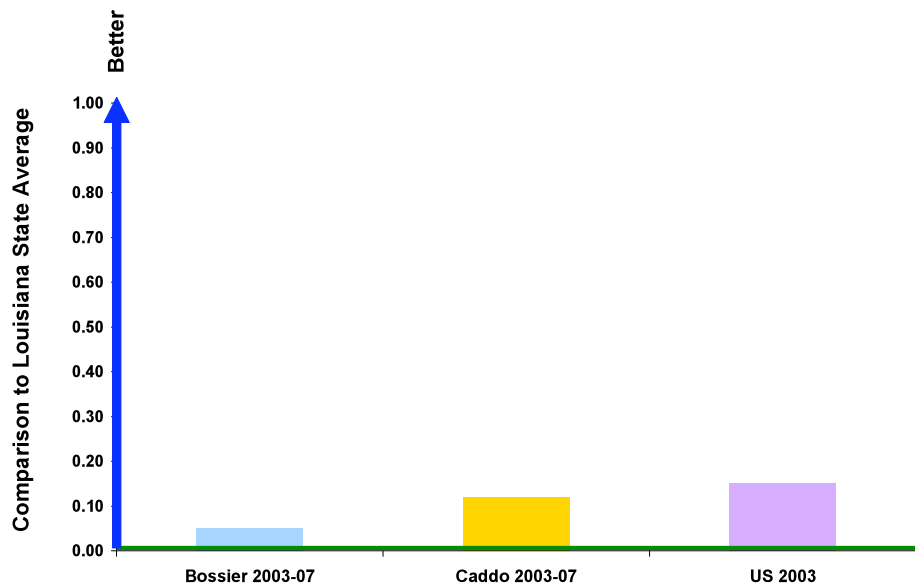
Figure A.24
Percentage of 12th Graders That Graduate Senior Year
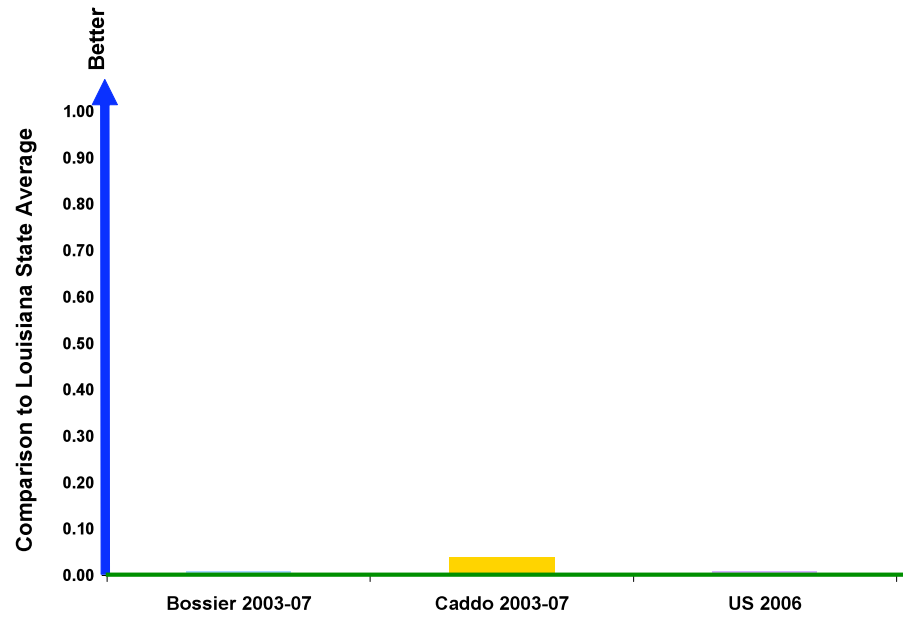
Figure A.25
Public School Expenditures per Student
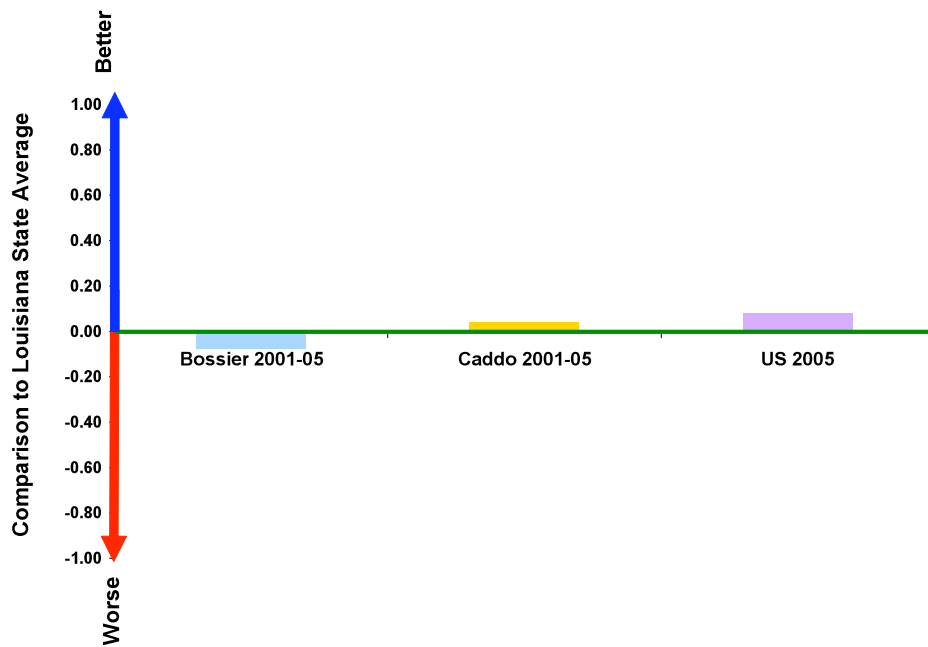
Figure A.26
First Time Freshman in College
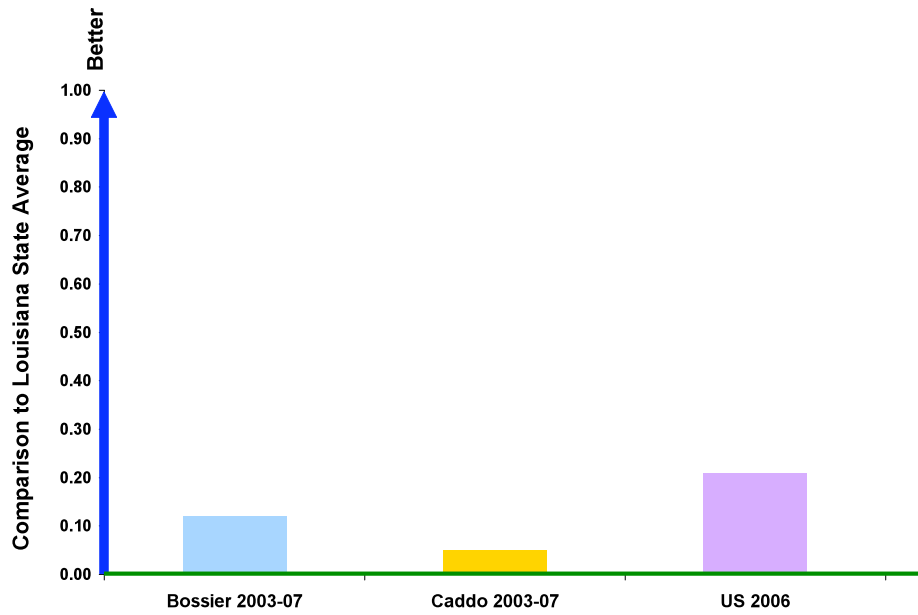
Figure A.27
Average Overall ACT Score
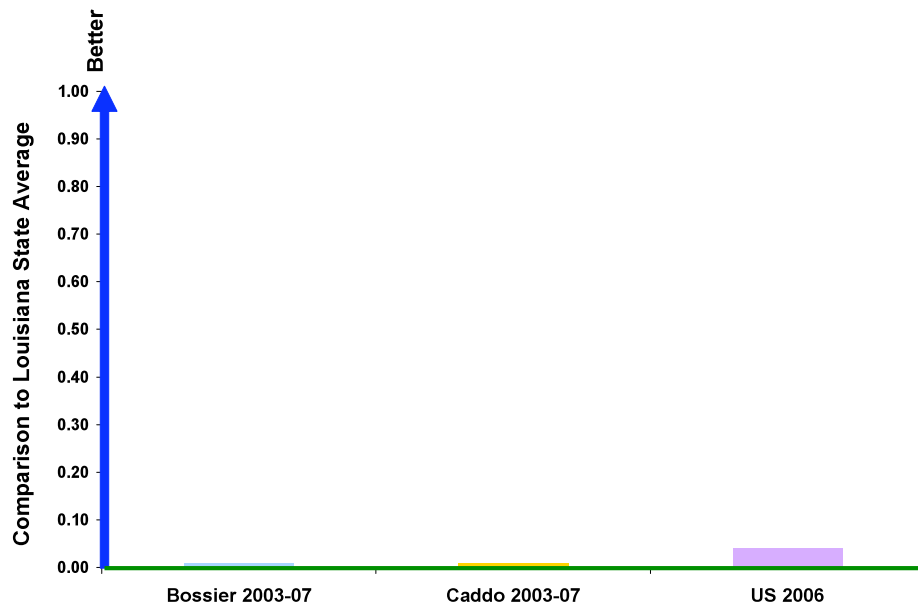
Figure A.28
Percentage of Public Schools with Classrooms of 20 Students or Less
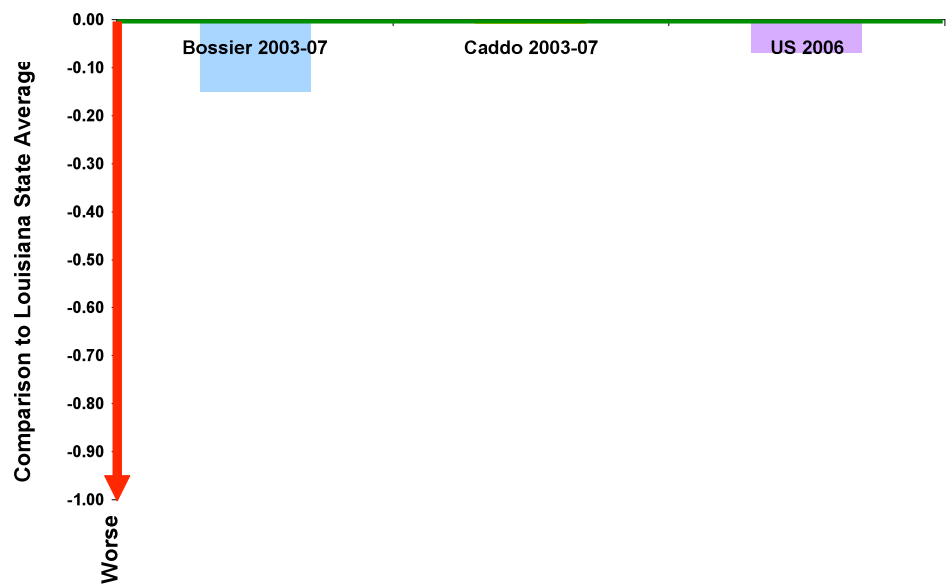
Figure A.29
Elementary and Secondary School Attendance
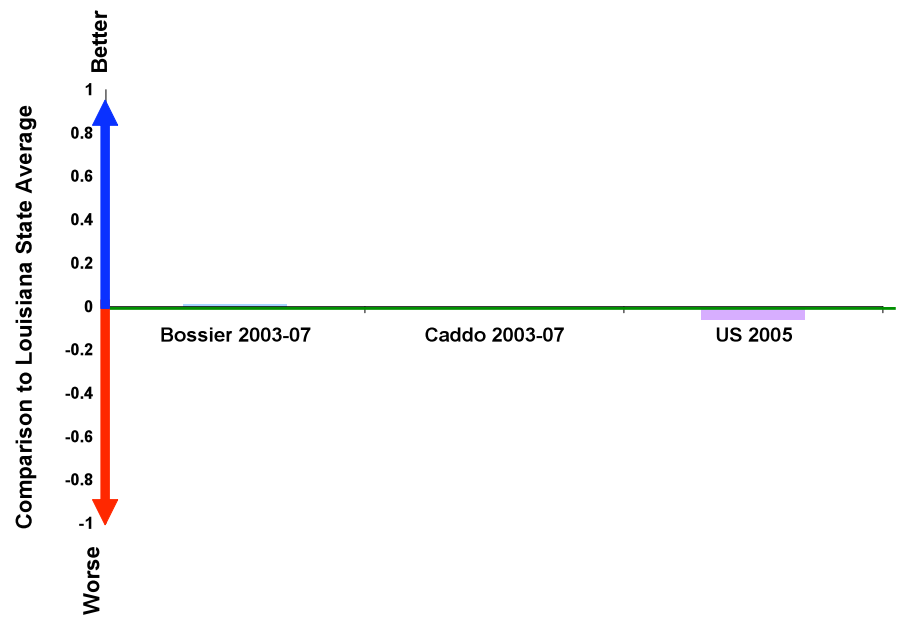
B. Needs Indicator Data Sources

Health Indicator Data Sources

Table B.1
Health Indicator Data Sources

Indicator	Measure	Source	Population
Adolescent Binge Drinking	Percentage of 8th/12th graders who had five or more drinks in a row in the last two weeks	Louisiana Caring Communities Youth Survey Results: 2002, 2004, 2006, 2008	Caddo Parish, Bossier Parish, Louisiana
Adolescent Binge Drinking	Percentage of 12–17-year-olds who had at least five drinks in one sitting in the past 30 days	http://datacenter.kidscount.org	Louisiana, United States
Adolescent Smoking	Percentage of 12th graders who smoked at least one cigarette in the past 30 days	Louisiana Caring Communities Youth Survey Results: 2002, 2004, 2006, 2008	Caddo Parish, Bossier Parish, Louisiana
Adolescent Smoking	Percentage of 9–12th	CDC Health People 2010	United States

	graders who smoked at least one cigarette in the past 30 days	Database: Tobacco Use	
LBW Babies	Number of babies weighing less than 2,500 grams per 100 births	http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana, United States
Children Experiencing Neglect	Number of child neglect allegations with a valid finding, per 1,000 children	http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana
	Number of children for whom allegations of child neglect were substantiated per 1,000 children	Child Welfare League of America NDAS Child Abuse and Neglect tables: "Number and Rate of Child Victims of Physical Abuse, Sexual Abuse, and Neglect," 2003, 2004, 2005, 2006	Louisiana, United States
Children Experiencing Physical Abuse	Number of child physical abuse allegations with a valid finding, per 1,000 children	http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana

Children Experiencing Physical Abuse	Number of children for whom allegations of physical abuse were substantiated per 1,000 children	Child Welfare League of America NDAS Child Abuse and Neglect tables: "Number and Rate of Child Victims of Physical Abuse, Sexual Abuse, and Neglect", 2003, 2004, 2005, 2006	Louisiana, United States
Children Experiencing Sexual Abuse	Number of child sexual abuse allegations with a valid finding, per 1,000 children	http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana
Children Experiencing Sexual Abuse	Number of children for whom allegations of sexual abuse were substantiated per 1,000 children	Child Welfare League of America NDAS Child Abuse and Neglect tables: "Number and Rate of Child Victims of Physical Abuse, Sexual Abuse, and Neglect," 2003, 2004, 2005, 2006	Louisiana, United States
Immunization Coverage	Percentage of children 19–35 months who were up to date with	Clinic Assessment Software Application: Results of Public Clinic Assessment, Louisiana	Caddo Parish, Bossier Parish, Louisiana

	immunizations at 24 months, according to the 4:3:1 schedule	1997–2005	
Immunization Coverage	Percentage of two-year-olds up to date with immunizations, according to the 4:3:1:3:3:1 schedule	http://datacenter.kidscount.org	Louisiana, United States
Infant Mortality	Number of deaths in children less than one year per 1,000 births	http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana, United States
Children Without Medical Insurance	Percentage of children under 19 who were uninsured at time of survey	Louisiana Department of Health and Human Services Report: "Parish Level Estimates of Louisiana's Uninsured Population," 2003, 2006, 2008	Caddo Parish, Bossier Parish, Louisiana
Children Without Medical Insurance	Percentage of children 17 and under who were not covered by health insurance at any point during the past year	http://datacenter.kidscount.org	Louisiana, United States

Children in Poverty with Medicaid Coverage	Number of children age 0–18 enrolled in Medicaid divided by number of children in poverty	Medicaid: datacenter.kidscount.org Children in Poverty: http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana
Children in Poverty with Medicaid Coverage	Average of: the number of children age 0–5 and the number of children age 15–18 enrolled in Medicaid divided by the number of children eligible in that age group	Medicaid Statistical Information System State Summary: 2003, 2004	Louisiana, United States
Babies Born to Mothers Receiving Early and Adequate Prenatal Care	Percentage of live births to women who received early and adequate prenatal care	http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana
Babies Born to Mothers Receiving Early and Adequate Prenatal Care	Percentage of live births to women who received early and adequate prenatal care	CDC Health People 2010 Database: Maternal, Infant, and Child Health	Louisiana, United States
Preterm Births	Number of live births	http://datacenter.kidscount.org	Caddo Parish,

	with gestational age less than 37 weeks per 100 live births		Bossier Parish, Louisiana, United States
Births to Teenage Mothers	Number of live births to females age 15–19 per 1,000 females age 15–19	http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana, United States

NOTES: NDAS = National Data Analysis System

Education Indicator Data Sources

Indicator	Measure	Source	Population
ACT Score	Average composite ACT score of students taking the test	Louisiana Department of Education Website: Data and Reports—ACT http://www.doe.state.la.us/lde/pair/1419.html	Caddo Parish, Bossier Parish, Louisiana
ACT Score	Average composite ACT score of students taking the test	ACT High School Profile Report: High School Graduating Class of 2008—Five Year Trends	Louisiana, United States
Student Attendance	Percentage student attendance	Louisiana Department of Education Website: Data and Reports—District Composite Report, Student Participation http://www.doe.state.la.us/lde/pair/1613.aspx	Caddo Parish, Bossier Parish, Louisiana
Student Attendance	Average daily	U.S. Department of Education IES National	Louisiana,

	attendance divided by fall enrollment	Center for Education Statistics, Digest of Education Statistics Website: http://nces.ed.gov/programs/digest/ Attendance: Table, Average daily attendance in public elementary and secondary schools, by state or jurisdiction: Selected years, 1969–70 through 2005–06 Enrollment: Table, Enrollment in public elementary and secondary schools, by state or jurisdiction: Selected years, fall 1990 through 2008	United States
Class Size	Percentage of classes with 20 or fewer students	Louisiana Department of Education Website: Data and Reports—District Composite Report, Characteristics http://www.doe.state.la.us/lde/pair/1613.aspx	Caddo Parish, Bossier Parish, Louisiana
Class Size	Average pupil-to-teacher ratio	U.S. Department of Education IES National Center for Education Statistics, Digest of Education Statistics Website: http://nces.ed.gov/programs/digest/	Louisiana, United States

		Table, Public elementary and secondary schools pupil/teacher ratios by enrollment size, type and level of school: Fall 1987 through fall 2006	
College Enrollment	High school graduates who enrolled in college as first time freshman in the fall semester	Louisiana Department of Education Website: Data and Reports—First Time Freshman Status Reports http://www.doe.state.la.us/lde/pair/1640.html	Caddo Parish, Bossier Parish, Louisiana
College Enrollment	Percentage of young adults age 18–24 enrolled in or graduated college	http://datacenter.kidscount.org	Louisiana, United States
12th Grade Graduation Rate	Number of graduates in school year 2004–2005 divided by the number of 12th	Louisiana Department of Education Website: Data and Reports—12th Grade Enrollment and Graduation Counts for 2004–05, for Districts and State (part of Annual Financial and Statistical Report, 2004–2005)	Caddo Parish, Bossier Parish, Louisiana

		graders enrolled in fall 2004	http://www.doe.state.la.us/lde/pair/1607.html	
12th Grade Graduation Rate	Number of graduates in school year 2004–2005 divided by the number of 12th graders enrolled in fall 2004	U.S. Department of Education IES National Center for Education Statistics, Digest of Education Statistics Website: http://nces.ed.gov/programs/digest/ Graduates: Table, Public high school graduates, by state or jurisdiction: Selected years, 1980–81 through 2006–07 Enrollment: Table, Enrollment in public elementary and secondary schools, by level, grade and state or jurisdiction: Fall 2004	Louisiana
High School Dropouts	Number of 9th-12th graders who have dropped out of high school per 100 9th–12th grade students enrolled	http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana

High School Dropouts	Teenagers between 16 and 19 not enrolled in high school and not graduates	http://datacenter.kidscount.org	Louisiana, United States
Students' Proficiency in English	Number of public school students identified as Limited English Proficient per 100 students enrolled	http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana
Students' Proficiency in English	Percentage of children age 5–17 who speak English less than "very well"	http://datacenter.kidscount.org	Louisiana, United States
Public School Expenditures Per Student	Current expenditures	http://datacenter.kidscount.org	Caddo Parish,

	divided by the number of students enrolled in public schools		Bossier Parish, Louisiana
Public School Expenditures Per Student	Current expenditures per pupil in fall enrollment	U.S. Department of Education IES National Center for Education Statistics, Digest of Education Statistics Website: http://nces.ed.gov/programs/digest/ Table, Current expenditure per pupil in fall enrollment in public elementary and secondary schools, by state or jurisdiction: Selected years, 1969–70 through 2005–06	Louisiana, United States
Pre-Kindergarten Enrollment	Number of children enrolled in public pre-kindergarten divided by the number of births four years ago	Enrollment: http://datacenter.kidscount.org Births: http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana
Pre-Kindergarten	Percentage of	http://datacenter.kidscount.org	Louisiana,

Enrollment	children age 3–5 enrolled in preschool, nursery, or kindergarten		United States
Teachers with Master's Degrees	Percentage of faculty with a master's degree or higher	Louisiana Department of Education Website: Data and Reports—District Composite Report, Characteristics http://www.doe.state.la.us/lde/pair/1613.aspx	Caddo Parish, Bossier Parish, Louisiana
Teachers with Master's Degrees	Percentage of faculty with a master's degree or higher	U.S. Department of Education IES National Center for Education Statistics, Digest of Education Statistics Website: http://nces.ed.gov/programs/digest/ Table, Highest degree earned, years of full-time teaching experience, and average class size for teachers in public elementary and secondary schools, by state: 2003–2004	United States
Teacher Salary in Public Schools	Average teacher salary, including	http://datacenter.kidscount.org	Caddo Parish,

	extra compensation		Bossier Parish, Louisiana
Teacher Salary in Public Schools	Average annual salary	U.S. Department of Education IES National Center for Education Statistics, Digest of Education Statistics Website: http://nces.ed.gov/programs/digest/ Table, Estimated average salary of teachers in public elementary or secondary schools, by state or jurisdiction: Selected years, 1969-70 through 2006-07	United States
4th and 8th Grade Student Test Scores	4th/8th graders who scored at or above proficient at Math/English Language Arts on LEAP	Louisiana Department of Education Website: Data and Reports—District Composite Report, Student Achievement http://www.doe.state.la.us/lde/pair/1613.aspx	Caddo Parish, Bossier Parish, Louisiana
4th and 8th Grade Student Test Scores	4th/8th graders who scored at or above proficient at	http://datacenter.kidscount.org	Louisiana, United States

	Math/Reading on NAEP		

NOTES: ACT = American College Testing; IES = Institute of Education Sciences; LEAP = Louisiana Educational Assessment Program; NAEP = National Assessment of Education Progress.

Poverty Indicator Data Sources

Table B.3
Poverty Indicator Data Sources

Indicator	Measure	Source	Population
Portion of Median Income Required to Cover Infant Child Care Costs	Cost for one infant in a class A child care center as a percentage of median income	http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana
Portion of Median Income Required to Cover Infant Child Care Costs	Average cost for one infant in a child care center divided by median income	Cost: National Association of Child Care Resource and Referral Agency, Research and Data, Supply, and Cost Website: (http://www.naccrra.org/randd/supply-and-cost) Median Income: U.S. Census Bureau American Fact Finder, Selected Economic Characteristics Website: http://factfinder.census.gov	Louisiana, United States
Children Living in Families Below Federal	Percentage of children under	http://datacenter.kidscount.org	Caddo Parish,

Poverty Level	age 18 living in families with incomes below the Federal Poverty Level		Bossier Parish, Louisiana, United States
Portion of People in Poverty Receiving EITC	Percentage of tax returns resulting in receipt of EITC divided by percentage of population in poverty	EITC: http://datacenter.kidscount.org Population in Poverty: http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana
Portion of People in Poverty Receiving EITC	Percentage of tax returns resulting in EITC divided by percentage of population in poverty	EITC: IRS Tax Usage Study, Tax Year 2006, January 1 through October 26, 2007 Website: http://www.irs.gov/taxstats/ Population in Poverty: http://datacenter.kidscount.org	United States
Portion of Children in Poverty That Receive Food Stamps	Percentage of children served by food stamp	Food Stamps: http://datacenter.kidscount.org	Caddo Parish, Bossier

	program divided by percentage of children under 18 living in families below the Federal Poverty Level	Children in Poverty: http://datacenter.kidscount.org	Parish, Louisiana
Portion of Children in Poverty That Receive Food Stamps	Percentage of children receiving food stamps divided by percentage of children under 18 living in families below the Federal Poverty Level	Food Stamps: U.S. Department of Health and Human Services Indicators of Welfare Dependence Annual Report to Congress 2007, Appendix A Website: http://aspe.hhs.gov/hsp/indicators07/index.htm Children in Poverty: http://datacenter.kidscount.org	United States
Students' Free/Reduced Price Lunch Eligibility	Percentage of public school students eligible for free or reduced price lunch	http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana
Students' Free/Reduced	Percentage of	U.S. Department of Education IES National Center for	Louisiana,

Price Lunch Eligibility	public school students eligible for free or reduced price lunch	Education Statistics, Digest of Education Statistics Website: http://nces.ed.gov/programs/digest/ Table, Number and percentage of public school students eligible for free or reduced price lunch by state: 2000–01, 2004–05, and 2006–07	United States
Median Income	Median household income	http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana
Median Income	Median household income	U.S. Census Bureau American Fact Finder, Selected Economic Characteristics Website: http://factfinder.census.gov	Louisiana, United States
Population in Poverty	Estimated percentage of the population with incomes below the Federal Poverty Level	http://datacenter.kidscount.org	Caddo Parish, Bossier Parish, Louisiana
Population in Poverty	Estimated	U.S. Census Bureau American Fact Finder, Selected	Louisiana,

	percentage of all people with incomes below the Federal Poverty Level	Economic Characteristics Website: http://factfinder.census.gov	United States
Unemployment Rate	Percentage of labor force unemployed on average during the year	Bureau of Labor Statistics, Local Area Unemployment Statistics Website: http://www.bls.gov/lau/#tables	Caddo Parish, Bossier Parish, Louisiana, United States

Appendix C. Dates and Agenda for Community Meetings

The dates and agendas for the community meetings are below. Two representatives of the Community Foundation (the Executive Director and the Director of Community Investment) attended the meetings along with 20 to 60 representatives from these sectors of the community: nonprofit organizations that served children and families, local businesses, grantmakers, faith-based organizations, school districts, volunteer organizations, postsecondary institutions, Latino and African-American organizations, women's organizations, health care providers, early education institutions, justice and law enforcement organizations, local government agencies, and others.

April 17, 2009, Meeting Agenda

- Why the foundation is focusing on health, education, and poverty: Findings from 2008 *Community Counts* report

- Goals of this project

- Introduction to RAND

- Proposed process for narrowing priorities

- Discussion of community needs

- Discussion of what it means to be "evidence-based"

- Suggestions for obtaining community input

- Suggestions for communicating to community

May 21, 2009, Meeting Agenda

- Review of project goals

- Defining "Best Practices"

- How to achieve effective implementation

- Discussion of community assets

June 24, 2009, Meeting Agenda

- Discussion of Needs-Assets-Best Practices Framework

- Approaches to needs assessment and discussion of relative utility for this application

- Examples of communicating needs data: Which method of display is most useful for this context?

- Approaches to asset inventories

- Example of best practices information: Reducing low birth weight

September 24, 2009, Meeting Agenda

- Review of Needs-Assets-Best Practices Framework

- Discussion of preliminary findings from needs assessment

- Discussion of assets that might address these needs

- Next step: adding best practices

- Continuing and expanding community engagement

- Communicating with the community

December 15, 2009, Meeting Agenda

- Review project objectives

- Describe project methods and framework

- Discuss literature review and analysis findings

- Potential next steps for community

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